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No. 99-830

Supreme Court, U.S.
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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX VOLUME I, PAGES 1 TO 240

DON STENBERG
Attorney General

L. STEVEN GRASZ
Deputy Attorney General
Counsel of Record
2115 State Capitol
Lincoln, Nebraska
68509-8920
(402) 471-2682

Counsel for Petitioners

SIMON HELLER
Counsel of Record
JANET BENSHOOF
PRISCILLA J. SMITH
SUZANNE NOVAK
THE CENTER FOR REPRODUCTIVE LAW & POLICY
120 Wall Street
New York, New York
10005
(212) 514-5534

JERRY M. HUG
ALAN G. STOLER
Historic Library Plaza
1823 Harney Street
Suite 1004
Omaha, Nebraska 68102
(402) 346-1733

Counsel for Respondent

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RELEVANT DOCKET ENTRIES

United States District Court for the District of Nebraska

6/12/97	1	COMPLAINT with request for trial at Lincoln with request for TRO and preliminary injunction. . . .
	–	
6/17/97	7	MEMORANDUM AND ORDER: by Judge Richard G. Kopf granting motion for temporary restraining order. . . .
	–	
8/14/97	19	MEMORANDUM AND ORDER: by Judge Richard G. Kopf re: request for a preliminary injunction is granted as provided herein; Defendants are . . . enjoined from enforcing LB23 against Plaintiff regarding his performance of D&X abortions on nonviable fetuses. . . .
	–	
2/17/98	36	PRE-TRIAL ORDER
	–	
7/2/98	46	MEMORANDUM AND ORDER: by Judge Richard G. Kopf that judgment will be entered by separate document . . . for the Plaintiff and against the Defendants; LB23 is declared unconstitutional as provided and that Defendants are permanently enjoined from enforcing LB23 against the Plaintiff, his patients and others similarly situated. . . .

8/10/98	49	JUDGMENT: by Judge Richard G. Kopf entered for the Plaintiff and against the Defendants . . . as applied to Dr. Carhart, his patients and others similarly situated, LB23 is declared unconstitutional. . . .
8/12/98	56	NOTICE OF APPEAL: by Defendants Donald Stenberg, Gina Dunning and Charles Andrews from District Court decision re: Judgment [49-1]. . . .

United States Court of Appeals for the Eighth Circuit

9/2/98	Civil Case Docketed. . . .
4/19/99	ARGUED AND SUBMITTED IN ST. LOUIS. . . .
9/24/99	JUDGMENT: . . . The judgment of the lower court is AFFIRMED in accordance with the opinion. . . .

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

LEROY H. CARHART, on behalf of himself and his patients obtaining abortions, Plaintiff, vs. DONALD STENBERG, in his official capacity as Attorney General for the State of Nebraska; MIKE MUNCH, in his official capacity as County Attorney for Sarpy County, and as a representative of all County Attorneys in Nebraska; DEB THOMAS, in her official capacity as Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, Defendants.	4:97CV3205 July 17, 1997 9:00 a.m. Lincoln, Nebraska

VOLUME I,
TRANSCRIPT OF PRELIMINARY INJUNCTION
PROCEEDINGS, HELD BEFORE THE
HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

* * *

[Henshaw, Direct]

[By Mr. Gans]

[p. 49] Q I'm going show to show you what's been marked as Exhibit 9, and I would like you to turn your attention to the 1996 report. If you could look at the first page of that report?

A Yes.

Q On page one, what does the report say about how many abortions were performed during 1996 in Nebraska?

A There were 5,214 abortions reported as being performed in Nebraska in 1996.

Q And if you could now turn to table 5 which I believe is the table concerning methods of abortion?

A Yes.

Q What does the State indicate about the methods used by physicians terminating pregnancies in Nebraska?

A Well the large majority of abortions are done by suction curettage. That's the method primarily used for first trimester abortions. Some were reported as sharp curettage. These are most likely D & E's. The Nebraska reporting form does not have a category for dilatation and evacuation, which is D & E, and in my opinion, physicians doing those would very likely count them as sharp curettage. Some might check off suction curettage. There are none reported as being by induction; that is, saline installation or Prostaglandin [p. 50] installation, even though those categories are on the reporting form. My assumption is that none were done. There were 49

reported as other, and it's my understanding that those are probably primarily – either Mifepristone or Methotrexate abortions which is a method of medically inducing a very early abortion before eight weeks.

Q So in your professional opinion, what is the procedures used after the first trimester?

A It would be D & E in Nebraska.

Q Okay. Are you familiar with the data collected by the CDC?

A Yes, I am. I use the data all the time.

Q All right. I'm going to show you Exhibit 17 ask you to identify that.

A This is a table from the 1992 Abortion Surveillance Report that's published by the Centers for Disease Control.

Q And what does the data on that chart indicate about the methods used to terminate pregnancies nationwide.

MR. SMITH: If I could, just for clarification, what exhibit are we on?

MR. GANS: 17.

MR. SMITH: Thank you.

THE WITNESS: This table cross-tabulates the method of abortion by weeks of gestation. It shows that at all points in gestation, curettage, which would include D & E, is [p. 51] the most common method used to perform abortions.

BY MR. GANS:

Q And is the data in that chart generally consistent with the data in Nebraska?

A Yes, it is, in that, as I just testified, either all or just about all of the second trimester abortions in Nebraska are done by D & E. This table shows that nationally, 86%, approximately, of abortions past 15 weeks are done by D & E, and that induction is fewer than 10%.

Q I would like to show you –

THE COURT: Counsel, let me just bring to your attention, we had a discussion before this witness testified about the difference between D & E and D & X. It is unclear to me, when your witness uses the term D & E, whether he intends to distinguish that procedure as we were talking about it, or whether he means to talk about it more generally. D & E can be included, intact D & E, as your colleague refers to. It's unclear to me what your expert means.

MR. GANS: Okay. I will try and clarify that.

BY MR. GANS:

Q In either the CDC data or the Nebraska data, do they – Is there a differentiation between the sort of more traditional D & E procedure or the variant that we have been discussing as intact D & E?

[p. 52] A The intact D & E or the D & X, I think, normally would be included under the D & E category here which would be curettage, so there is no way to

quantify how many of the D & X abortions are done based on the statistics collected by the State or the CDC.

* * *

[p. 53] Q Okay. I'm going to ask you some questions about the impact of the act on abortions performed in Nebraska after the first trimester. I would like you to assume that as a result of the act, abortions in Nebraska stopped performing D & E's, either the more traditional D & E procedure involving dismemberment, or the variability where the fetus is removed intact, stopped doing both, both variants of the D & E. What in your professional opinion would be the impact on women in Nebraska seeking second trimester abortions?

MR. SMITH: I'm just going to object. There is not [p. 54] adequate foundation.

THE COURT: What foundation is lacking?

MR. SMITH: Frankly, I think the assumption makes his opinion irrelevant. I mean, I don't think it's properly a subject of expert opinion at that time.

THE COURT: That's the foundation that's lacking.

MR. SMITH: Yes.

THE COURT: The objection is overruled, and I will understand his testimony to be based on inferences drawn from statistics. Go ahead. The witness may answer.

THE WITNESS: That would pose a serious barrier to women in Nebraska seeking second trimester services. The options would be to try to find a hospital

where induction abortion could be performed or travel out-of-state or continue the pregnancy, and in Nebraska, hospital services are not readily available and as we saw.

MR. SMITH: Your Honor, I would object to his opinion that hospital services are not readily available as no foundation for that opinion.

THE COURT: Would you like to lay additional foundation on that issue?

BY MR. GANS:

Q Have you ever done any research about the availability of abortions in hospitals in Nebraska?

A As I mentioned, our survey of all abortion providers in [p. 55] the country, of course, covers Nebraska, and we get a – from that survey a count of all hospitals in the country that we have actually been able to locate that – where abortions are performed.

THE COURT: The objection is overruled. You may continue.

BY MR. GANS:

Q And based on the data you collected, how many hospitals in Nebraska reported performing abortions?

A Our last survey was conducted in 1992. At that time, three hospitals in Nebraska reported any abortions at all, and those hospitals reported very few. In fact, together, they reported doing 25 abortions in the State which is what, only four-tenths of a percent of the abortions performed in the state in that year.

Q And of those three hospitals that performed abortions, do women go directly to the hospital to obtain an abortion?

A On our questionnaire, we had the question, can a woman arrange directly with the hospital, or must she go through an attending physician. Two of the three hospitals said that she must go through an attending physician. The third did not answer the question, so based on that, I conclude that a woman could not arrange directly with the hospital to have an abortion under present circumstances.

Q And of the three hospitals that you found performed [p. 56] abortions, did any of the hospitals limit the circumstances in which a physician could perform abortions?

A We didn't ask that question, but one of the respondents wrote onto the form that abortions are done only for therapeutic reasons.

Q Based on this data you collected, do you have an opinion about whether a woman would be able to obtain a second trimester abortion in Nebraska if D & E's, including both the traditional and the intact variety, were unavailable as a result of the act?

A Well, nationally, about 10% or more of abortions are done during the second trimester. If that were applicable to Nebraska, that would be over 500 abortions during the second trimester. If you just look at abortions past 14 weeks, it would be, maybe, on the order of 300 abortions. Given the fact that at least in 1992, only 25 abortions were performed in hospitals, I think it would

be difficult for most women who needed that service to be able to obtain it from a hospital.

Q Have you ever conducted research on the difference in cost between a D & E performed in an outpatient clinic and an induction performed in a hospital?

A Yes.

Q And how did you conduct that research?

A In our 1992 survey, nonhospital facilities were asked [p. 57] the charges for abortions at 16 weeks and 20 weeks, and then as a supplement to the survey, we did a telephone survey of some small sample of hospitals nationally where we knew abortions were being done and asked the same question, questions, so with that information, we were able to calculate the average charge in facilities, nonhospital and hospital facilities, of abortions done at 16 weeks and 20 weeks.

Q And what conclusions did you reach?

A We concluded that a clinic abortion at 16 weeks cost in the range of 500 to $600, whereas a hospital abortion done by installation, that is usually saline or Prostaglandin, averaged $2,246. At 20 weeks, the clinic abortion cost 900 to a thousand dollars, and the hospital abortion cost about $2,400.

Q And do you have an opinion as to whether the cost differential would affect women's access to second trimester abortions if D & E's were unavailable as a result of the act?

A There is evidence that the cost of abortion services proposes a barrier to women who need the service,

so I would conclude from that that if the cost were much higher, that it would tend to prevent some women from obtaining the service.

Q You've stated earlier that the – You stated earlier that if D & E's, were unavailable as a result of the act, if they were going to get an abortion in Nebraska, would have to [p. 58] seek an abortion in a hospital. What other impact would that have on their access to the service?

A Well, the other option is to travel out-of-state for a second trimester abortion.

Q Let me rephrase it. Would that have any option on the time of the gestational age when they would obtain an abortion?

A I'm assuming that if they could get an abortion in the hospital, it would probably be more difficult than it is now to simply go to a clinic, so that – and it would be more expensive, so the time it would take to arrange to have the abortion would be greater than it is at present. First of all, we know from studies of the reasons people delay having abortions, that the time taken to make the arrangements is a major reason that people are delayed to the second trimester; that is, the time to get together the money and to find out where to go and actually make the appointments and get there, so my conclusion would be that even if they were able to find the service, that there's a good – that for a fair proportion of the women, their abortion would be later than it would have been otherwise.

Q Would that delay have an impact on the health risks for women on second trimester abortions?

A There are many studies that show both complication rates and mortality rates from abortion increase with each [p. 59] additional week of gestation past around eight weeks, so additional delay would increase the risk of both morbidity and mortality.

Q And starting with mortality first, what would be the increased risk?

A Well, say, you were delayed from 13 to 15 weeks to 16 to 20 weeks. One group to the other, the mortality is about three times as great at 16 to 20 weeks as it is at 13 to 15. It's still not high. It's still, at 16 to 20 weeks, no higher than childbirth, but it's much greater than it is earlier in gestation. Sadly, your complications, we've calculated that the rate of complications increases by about 20% for each additional week of gestation from about eight weeks on.

Q And you testified now about three obstacles; one, availability of hospitals; two, the costs; and three, delay. Would some women in Nebraska be unable to overcome these obstacles and be forced to carry to term?

A Well, we know now that there are numbers of women who are unable to get abortion services at all because of lack of access, so it stands to reason that if you increase the barrier, that will cut off an additional group of women from having abortions.

Q You stated earlier that if D & E's were unavailable as a result of the act, some women might have to go out-of-state [p. 60] to obtain an abortion, is that correct?

A That's right.

Q And if a woman had to travel out-of-state to obtain an abortion in Nebraska, where could she go in the surrounding states?

A I checked our data on the surrounding states. The places she could go are Iowa City, Iowa; Kansas City; Wichita, Kansas; Minneapolis; or Denver.

Q And how far would she have to travel to each of these places?

A Well, it's in the hundreds of miles, depending on where in Nebraska she's coming from, of course.

Q And in your opinion, what would be the effect of forcing women to travel to these other states?

A We know that travel distance has an impact even on first trimester abortions. For these abortions, the impact would be greater because the D & E procedure, after maybe 14 weeks, usually requires either two days, or at later points in gestation, three days, so the woman would either have to make the trip twice or three times or stay overnight at the – in the city where she had the – or where the clinic existed, so yes, I think that would be a significant additional barrier.

Q And would you need to travel to the other states for some women to carry to term?

A Undoubtedly, there are some women who would not be able [p. 61] to maneuver that and to get to the other states.

* * *

[p. 63] BY MR. GANS:

Q So far we have been examining a type of situation in which D & E's were unavailable in Nebraska relative to the act. Do you have an opinion as to the effect on women seeking second trimester abortions in Nebraska, the physicians could perform both the intact and the dismemberment variety beginning at 19 weeks LMP through the use of fetal injection to cause fetal demise?

A Obviously, most women who have second trimester abortions have them before 19 weeks, so it would mean that most of the women would be forced to wait until 19 weeks before they could end their pregnancies, and that, of course, has the same effects. That's a delay. It would have the effects I've already discussed.

* * *

[p. 64] THE COURT: Counsel, you may inquire.

CROSS-EXAMINATION

BY MR. SMITH:

Q Dr. Henshaw, would your opinions be different if LB 23 did not, in fact, prohibit D & E's?

A Almost everything I said was based on the assumption that D & E's would be banned.

Q Okay. So the answer to my question is – yes, your opinions would be different?

A Yes.

Q And have you read the Legislative Bill 23?

A Yes, I have.

Q You've read the definition of partial-birth abortion in that?

A Yes, I have.

Q And does that definition use the term D & E?

A No, it doesn't.

Q Does it use the term dilation and extraction?

A No.

Q Does it specifically use any medical terminology for medical abortion procedure?

A Not as I recall.

Q Are you aware that the United States Supreme Court recently affirmed a state statute which proscribed anyone from doing an abortion who is not a physician?

[p. 65] A Yes, I am.

Q Have you done any studies on the effect of state regulations that require only physicians to do abortions?

A No, I haven't.

Q Would you expect that there would be an effect on the cost if only physicians can do abortions rather than physicians and physician's assistants?

A I think there would be a minor effect. Physician assistants can only function under the direct supervision of a physician, so the physician must be present or at least supervising the physician assistant.

Q Are you aware that under the laws of the State of Nebraska, a physician only has to be present 20% of the time for his physician assistant's duties?

A No, I'm not.

Q When you were using the terminology D & E, or in answering questions referring to D & E, you meant dilation and extraction procedures, is that what –

A Yes.

Q What's your understanding of what that procedure is?

A Excuse me. Dilation and evacuation.

Q I'm sorry. What was your understanding? That's why I asked the question. What was your understanding of the procedure?

A It's generally any procedure using instruments to end [p. 66] the pregnancy after either 12 or 14 weeks, depending on your definition.

Q Does the definition, or at least the context, in which you were using it, have as an element the intent to remove a part of the fetus from the uterus while it's alive?

A Well, the intent is to end the pregnancy by removing the fetal parts. Often, the operator knows the fetus is alive when he or she begins removing the fetal-parts. Beyond that, I can't talk about whether that is intent under the statute or not, but there is an intent to remove fetal parts that are living parts.

Q Well, you would agree that your understanding of D & E would simply involve using instruments to remove fetal parts from the uterus?

A That's right.

Q Do you still have Exhibit 7 in front of you, sir? That's the AMA report. If you do, I would ask you to just turn to that.

A Yes.

Q And just portions of the report I'm going to refer to and ask you if you agree or disagree with what it states. If you would, on the first page of Exhibit 7, line 35 through 36, it says, "AGI collects data directly from abortion providers."

A Yes, that's correct.

[p. 67] Q You understand the report to be AGI refers to the Alan Guttmacher Institute?

A Yes, it does.

Q So your institute does collect data directly from the abortion providers, is that correct?

A Yes, it does.

Q And on line 38 on the same page, it says, "However, AGI does not collect data on gestational age," is that correct?

A That's generally true. We actually, in our survey, we ask how many abortions the provider did the past 12 weeks, and we ask the gestational limit of the abortions done in the facility, so that statement isn't completely

true. The meaning of it is that we would rely on the CDC data on the number of abortions at each gestational age rather than try to calculate our own from our own survey.

Q If you would turn to the last page of Exhibit 7, or I'm sorry, the last page, it's page number 11, the last page. If you would turn to page number 11 of Exhibit 7?

A Yes.

Q And line 11, the last sentence of that full paragraph, it states, "However, more research on major complication rates associated with various procedures and by gestational age is needed before any confirmed conclusions about the relative safety and procedures can be made." Do you see that statement correct?

[p. 68] A Yes.

Q Do you agree or disagree, or do you have a basis to agree or disagree? I phrased that wrong. Let me ask you first, do you agree or disagree with that statement?

A Well, I think it's a question of which procedures are being referred to here. If it's, for example, it's well demonstrated that laparotomy – excuse me – hysterotomy is more dangerous than other abortion procedures. If you are referring to installation versus D & E, or D & E versus D & X, I would agree with that statement.

Q And when you use the term installation, would that be synonymous with an induction procedure?

A For the purposes here, yes. Induction could – That term could be used to refer to very early abortion

and medical abortion very early, but in the second trimester, most induction abortions would be installation, but not all, not all.

Q And continuing on page 11 of line – of Exhibit 7, the very last sentence says, "More systematic research is needed on complications and complication rates associated with various types of abortion procedures at 13 weeks of gestation and beyond." Do you agree or disagree with that statement?

A Yes, I think more research would be very useful.

Q And that's the business you're in is the research business, is that correct?

[p. 69] A Yes.

Q Now, also on Exhibit 7, on page 7, line 29?

A Yes.

Q Says, "Since the 1970's, vacuum aspiration, also referred to suction curettage, has been the most common procedure used to induce abortion in the first trimester," and then it has, in parenthesis, from the 6th through the 12th week of gestation. Do you agree or disagree with that statement?

A No, I agree with that.

Q And if you would, turning to the Exhibit 9, the 1996 Nebraska Statistical Report of Abortions, on page number four?

A Yes.

Q Table 5?

A Yes.

Q And that reflects at least the 5,161 abortions in Nebraska in 1996 were by the suction and curettage method?

A Yes.

Q And it shows a percent of 99%?

A There is – Yes.

Q And have you looked at the statistical reports for the previous years that the Nebraska Department of Health issues?

A I have looked at them briefly.

Q Would you agree, I mean, they'll state on their face, [p. 70] but would you agree as general principle that those reports would reflect that the suction curettage method of abortion has been the method reported as performed consistantly in the high 90%?

A I think that high 90% would include some second trimester abortions where probably a combination of sharp curettage and suction were used. As I mentioned, there is no line on the form for D & E, so the person doing a D & E ordinarily uses both sharp and suction curettage. Some of those are probably reported as both suction and sharp. You'll notice that the total is 5,764 which is much larger than the number of abortions performed which is 5,214.

Q Now, Dr. Henshaw, do you – do you or the Alan Guttmacher Institute have any affiliation or association with the Center for Reproductive Law and Policy?

A No.

Q Do you have or have you ever had any affiliation with Planned Parenthood?

A Yes.

Q What is that? Would you just explain what it would be.

A We are a special affiliate of Planned Parenthood. One of the meetings that is – that we participate in their pension plan. We see some funding from Planned Parenthood, something like 10 to 15% of our funding primarily for our Washington office.

[p. 71] Q Does that mean that your personal pension depends upon some funding from Planned Parenthood?

A No.

Q What does it mean?

A It means that we have shared a pension plan. The funding for our pensions come from our own organization which is independent of Planned Parenthood.

Q Have you personally been on the board of directors for Planned Parenthood?

A No.

Q Have you been on the board of directors for the Abortion Federation?

A The National Abortion Federation, yes.

Q And when were you on the board of directors for that?

A From around 1990 to 1996, something around then. Not '96, '95, '90 to '95 with them. It's on my CV.

Q And what does that organization, what is its purpose and function?

A Its purpose is twofold: To help abortion facilities provide services and to preserve access to abortion services for women.

Q And you understand that the plaintiffs' counsel in this case, they are hired or employed by the Center for Reproductive Law and Policy, correct?

A Yes.

[p. 72] Q And is that, is the Center for Reproductive Law and Policy, is that located at 120 Wall Street in New York?

A Yes it.

Q Where is the Alan Guttmacher Institute located?

A We're at the same address.

Q Now, are you familiar with the federal legislation on partial-birth abortion?

A Somewhat.

Q Do you know whether or not the Center for Reproductive Law and Policy has been involved in any activities lobbying or opposing that legislation?

A I don't have firsthand knowledge of it.

MR. GANS: Objection; relevance.

THE COURT: Pardon me just a moment.

MR. GANS: Objection; relevance.

THE COURT: Overruled. You may answer.

THE WITNESS: I don't have firsthand knowledge of their lobbying activities. I believe they are opposed to the legislation.

BY MR. SMITH:

Q Do you agree that you cannot make accurate judgments on what might happen in the future based on what happened in the past?

A That's a very general question. Sometimes you can make an accurate judgment of the future from the past. Sometimes [p. 73] you can't.

Q Well, you would have testified –

THE COURT: We aren't here to debate George Santianna's –

BY MR. SMITH:

Q Well, you did testify in the Eastern District of Michigan in the case filed there by Dr. Evans against the attorney general, correct?

A Yes.

Q And would you agree that you were asked the following question, and you gave the following answer: The question: "Do you think that you can make accurate judgments about what might happen in the future based on what happened in the past?" And your answer was, "No, I wouldn't say accurate, no." Would you agree?

A In that context, I would stand by that answer.

Q And would you agree that you also testified in that case that not too much of my work involves predictions. It's more descriptions of what has happened.

A Yes.

Q And that, in fact, is what your work primarily is, is describing what has happened historically?

A That's right.

Q You don't purport to be a fortune teller?

A That's right.

[p. 74] Q You would agree it's not a static world, and that the market changes in response to market conditions, what the laws are in at any particular time?

A That, again, is a very general question. Sometimes yes and sometimes no.

Q I know what I wanted to ask. Does your statistical research, at least on induction procedure in the second trimester abortion, have you done studies on whether those are primarily performed in or out of hospitals?

A They almost always involve hospital care. There are a few physicians who will begin the procedure outside of a hospital. As far as I know, they either always or almost always seek hospital care for the woman during the labor and delivery.

Q And just so we're on the same wavelength, by an induction, we are talking about a procedure in which the physician would induce labor prematurely for purposes of an abortion?

A That's correct.

Q Now, as far as what your studies have shown statistically, and if you know, as far as the percentages of inductions performed in hospitals versus outside of hospitals, such as in clinics?

A As I say, I'm not aware of any substantial number of induction procedures being done in clinics. I don't know [p. 75] that it's ever done actually.

Q Have you done any research to determine why that is the case?

A I've heard physicians talk about it. That's the extent of my knowledge.

Q But as far as actually doing any statistical studies or gathering any, what you would consider legitimate emperical data, have you done that?

A Actually, that question is on our survey that's going to be sent out shortly, but in the past we have never asked that question, mainly because I wasn't aware that it was actually an issue. I had never heard of induction abortions being done outside of hospitals.

Q At least from your research, would your research indicate that hospitals have better facilities, in general, than clinics?

A I think you have to specify better facilities, what you mean by that.

Q More equipment, protocols, staffing to address concerns of maternal health than a clinic would?

A I think that in many cases, clinics are better equipped to provide high-quality abortion service because they are focused on that particular service. The staff is specifically trained for it, and the equipment needed for it is there. There are many hospitals where abortion patients [p. 76] are cared for by people who deliver babies, do all kinds of other things, and may not understand the special problems of abortion patients, may be even unsympathetic to them.

Q Do you actually have any data to support what you just said, or is that your speculation?

A I have data to show that most hospitals where abortions are done do very few abortions, so it's impossible that the staff would be specialized in abortion services in that circumstance.

Q And have you any data or statistics to support your statement as far as the caring attitude of hospital staff?

A I would have to do some research. I can't think of studies right now, but they might exist.

Q Are you aware of any studies, data that would explain why hospitals would do inductions versus dilation and evacuations, or at least why they would primarily do inductions rather than dilation and evacuations?

A I think they primarily do dilation and evacuation. Most hospital abortions, to my knowledge, are done by D & E.

Q It's just when we are talking induction procedures, those are primarily done in a hospital but not in a clinic?

A That's right.

MR. SMITH: Nothing further.

THE COURT: Counsel, you may inquire.

MS. WALZ: No questions. Thank you.

[p. 77] . . . BY THE COURT:

THE COURT: Doctor, before you step down, I have a couple of questions. Would you look at Exhibit number 7 and page 8 of that exhibit?

THE WITNESS: Yes.

THE COURT: I'm going to be referring to the last paragraph. In that last paragraph, describes the D & X [p. 78] procedure and it states, and I quote, "According to the American College of Obstetricians and Gynecologists, intact D & X is comprised of the following elements: Deliberate dilation of the cervix, usually over a sequence of days, instrumental conversion of the fetus to a crippling breech, breech extraction of the body, accepting the head, and partial evacuation of the intracranial contents of a living fetus to affect vaginal delivery of a dead but otherwise intact fetus." Now, when I speak of D & X, that's what I mean?

THE WITNESS: Yes.

THE COURT: Okay: Are there good numbers about – that would tell us how many D & X as opposed to D & E procedures are being conducted nationally?

THE WITNESS: There are no good numbers. The only way to get numbers is to actually try to find the doctors doing them and estimating how many they do. To

my knowledge, there are only a few doctors nationally who do large numbers of D & X abortions.

THE COURT: I take it from that answer that the center that you represent then, has not endeavored to distinguish between the two for purposes of data collection?

THE WITNESS: It's only recently become an issue at all. In our new survey, we are going to be asking that question, but I hadn't heard the term in 1992, and it wasn't [p. 79] a political issue. Even today, it isn't really a medical issue, but it is a political issue.

THE COURT: What do you mean by that?

THE WITNESS: Well, in my opinion, the D & X is one type of D & E. There are many types. The only reason to single that out for special interest is because it has special political significance.

* * *

[Carhart, Direct]

[p. 81] BY MR. HELLER:

Q Please state your name for the record.

A LeRoy Harrison Carhart.

Q What is your profession?

A I'm a physician.

Q Before I begin asking you questions, I just want to provide you with copies of some of the exhibits that I'm going to ask you questions about. I'm giving you copies of Exhibits 7, 11, 12, and 16. If you could look at Exhibit 16. Do you have that one there?

A Yes, sir, I do.

Q Can you identify that document?

A It's my curriculum vitae.

Q Does that document accurately characterize your experience and background?

A Yes, sir, it does.

Q Can you tell me your educational background?

A Undergrad, I have a Bachelor's in accounting and finance from Rutgers University in New Jersey. I have further Bachelor, B.S. work from Saint Mary's University in Texas. That was in transferring. Completed my pre-medical training in 1970 – I'm sorry – 1965. Medical school was at Hahnemann Hospital and University in Philadelphia in 1973. My internship was with United States Air Force in Washington, D.C. I was in a medical, rotating internship, and my [p. 82] residency was at Hahnemann Hospital, and finished at one of the affiliation of Hahnemann, my last two years at Atlantic City Medical Center.

Q Have you been licensed to practice medicine?

A Since 1973 in Pennsylvania. I'm sorry. Since 1974 in Pennsylvania.

Q Do you currently have – Are you currently licensed to practice medicine in any states?

A Yes, sir, I am.

Q Which states are you licensed?

A I will go through the list of these here. Currently Nebraska, Pennsylvania, New Jersey, Iowa, Ohio, Indiana, Kansas, and Wisconsin.

Q Are you currently practicing medicine in Nebraska?

A Yes, sir, I am.

Q Would you describe your practice here in Nebraska?

A I run a family practice type of environment, general medical practice with a specialized abortion facility practice.

Q How long have you had that practice?

A Since 1985.

Q Since 19 – I will withdraw that. How long have you been practicing in Nebraska?

A I practiced since 1978. Excuse me. From 1978 until 1985 as a member of the United States Air Force.

[p. 83] Q In 1996, how many abortions did you perform in Nebraska, if you know?

A Approximately 800.

MR. SMITH: I'm sorry. Was it '96? Just for clarification, I wasn't sure if he asked '86 or '96.

THE COURT: My understanding was 1996.

THE WITNESS: That was my understanding, 1996.

BY MR. HELLER:

Q At what gestational ages of pregnancy do you perform abortions?

A We will – From the time of a woman's confirmation that she is pregnant, through fetal viability.

Q Can you give – Well, how do you measure gestational age?

A We use ultrasound for all of our patients and compare that with their menstrual dating.

Q If you were to try to quantify a particular gestational age, do you do it in a number of weeks?

A Yes, sir.

Q And where are the number of weeks measured from?

A From the first day of the last menstrual period.

Q So again, going back to the question about what gestational age is, what would be approximately the earliest gestational age you would perform an abortion?

A The earliest we've done is two weeks and two or three [p. 84] days. I'm sorry. Well, probably – three weeks from the last menstrual period. As soon as the woman has had a positive pregnancy test, we have done women one day after that which would be, if they conceive on the 14th day, which we assume, probably five to seven days post that date.

Q Do you use the same method of abortion for all the abortions you use, or do you use different method?

A Different methods.

Q Let's start with – Well, do you use different methods, depending on the gestational age or on other factors?

A Gestational age is one of the factors, but there are medical factors that can influence a decision also.

Q Tell me which methods you use in the overall methods.

A Overall, we use Methotrexate and Mifepristone – Methotrexate and Misoprostol combination for very early terminations. We use RU 486 and Mifepristone – RU 486 which is Mifepristone with Misoprostol for women that are under eight weeks from the sixth – or actually, from the fourth week to 14, 15 weeks. Occasionally, we will use suction, vacuum aspiration. At about the 12th or 13th week, we usually use curettage with vacuum aspiration up through the 15th, 16th week, after that 16th week, generally, it's a dilatation and evacuation procedure, and after the 18th week, we will use – Actually, that's not true. After the 16th week, we will use a partial form of induction to speed the [p. 85] process.

Q Just so I'm clear about this, when you are talking about a partial form of induction, does that mean you use –

A The old –

Q Well, could you tell me what that means?

A The old or classical definition of induction would include the saline or Prostaglandin installation into the uterine cavity, and then waiting for fetal demise, and then using drugs to cause the uterus to dilate or the cervix to

dilate and the uterus to contract. We don't do the installation portion of that. We do use Prostaglandin to aid in cervical dilatation, and we do use drugs that cause the uterus to contract.

Q Are those drugs used to augment surgical procedures, or are they used standing alone to terminate pregnancy?

A They are used to augment the surgical procedures.

Q Are the only procedures you do that do not involve surgery the ones you mentioned, Methotrexate and RU 486?

A They normally don't involve surgery, and the study that we're a part of, approximately three-tenths of 1% have used surgery as a backup.

Q Let's focus now on the second trimester abortions. By that, I mean abortions after 14 weeks from the LMP I'm going to use LMP as abbreviation for the first day of the woman's last menstruation period, is that all right?

[p. 86] A Yes, sir.

Q For second trimester abortions after 14 weeks, are you aware of methods, other than the ones you use, that can be used to perform those abortions?

A Yes, I am.

Q What methods are they?

A The saline or Prostaglandin induction and hysterotomy come to mind, being the most common, and hysterectomy is occasionally used.

Q What fees do you charge at different – Excuse me. I will withdraw that question. What fees do you charge for abortions?

A Okay. Can I use my notes, or how do you –

THE COURT: Certainly.

THE WITNESS: Our medical procedures are $350, and we are assuming a cash payment, if that's all right with the Court. The medical procedures would be $350. A surgical procedure from the fourth week, which is two weeks after conception through the beginning of the 12th week or 11 weeks, six days, our price is $275. Twelfth and 13th week, it goes to 375. The 14th and 15th week, it goes to 425, and the 16th through the 17th week, it goes to $600. Each of those procedures, the patient has an option to add IV sedation to her procedure if she elects to do that. There is an additional charge of $60 through the 17th week. After the [p. 87] 18th week, we have factored that in because we use – I have sedation for almost all of our patients unless there is a reason not to or the patient has a desire not to.

BY MR. HELLER:

Q What are your fees for after 18 weeks?

A The 18th and 19th week, our fees go to $895. The 20th and 21st week, $1,250; the 22nd through the 23rd week, six days, are $1,850; and 24th week and above would be by a personal discussion or arrangement with the patient.

Q You indicated earlier that you do abortions through the point of fetal viability?

A Yes, sir.

Q If you see a woman who needs an abortion or wants an abortion after viability, do you refer her elsewhere?

A I will. If there is no medical indication, I will refer her elsewhere. If she has a – If she herself has a medical indication or the fetus has a medical indication of not being viable, then we would not refer.

Q Where do you –

A Not necessarily refer her.

Q Where do you refer her?

A I generally refer to George Tiller in Wichita, Kansas.

Q Do you refer women to other abortion providers in Nebraska?

A No, sir, I do not.

[p. 88] Q Do you receive referrals from other physicians in Nebraska?

A Yes, sir, I do.

Q Can you estimate approximately how many different physicians within Nebraska have referred women to you for abortions?

A No. I have never kept that list, but it's – I can state probably well over 15 or 20 that I'm aware of, maybe much greater than that. I don't – I couldn't –

Q One of the documents I handed you, which is one that is not marked as as an exhibit, is a copy of Legislative Bill 23. Do you see that there? I hope I did give it to you.

A Everything I have is marked as an exhibit.

Q All right. Well, then, I'll have to give you one. Have you read this document before?

A Yes, I have.

Q I would like to call your attention to this version of it, page four of the document. There is a subsection 9 that contains a definition of partial-birth abortion. Do you see that?

A Yes, sir.

Q First, is partial-birth abortion a medical term?

A I have not seen it discussed in medical discussions other than in response to the bills that have been before the federal and local state courts, so I don't think on pure [p. 89] physician-medical basis, there is not a term partial-birth abortion.

Q For example, are you aware of any medical textbooks that use that term?

A I do not believe there are any textbooks that use that term.

Q Looking at the second sentence of that subsection 9, do you see the part that says for purposes of this subdivision, the term partially delivers vaginally a living and unborn child before killing the unborn child means deliberately and intentionally delivering it to into the

vagina a living, unborn child, or substantial portion thereof for the purpose of performing a procedure where the person performing such procedure knows will kill the unborn child and does kill the unborn child?

A Yes, sir.

Q I want to focus your attention on the term substantial portion. The portion that says a living, unborn child, or a substantial portion thereof. What is your understanding of what substantial portion means?

A I do not understand what substantial portion is.

Q What are the range of possibilities it could mean to you?

A I think it could mean any identifiable part of the fetus. I think it could mean the umbilical cord. I think it [p. 90] could mean an extremity, I think it could mean a portion of an extremity, a foot, a toe, a hand, a finger. I think it could mean a portion of the skull, if it's a face-first presentation, where the forehead protrudes from the cervical os before anything else comes out.

Q Also in that same sentence, there is the term living, unborn child. What is your understanding of what that phrase means?

A I think medically, it has no meaning. I think politically, it has an inflammatory meaning.

Q Well, let me – Let's focus on the term living. What is your understanding of what – Let me ask you a different question. Someone said to you a living fetus, what is your understanding of that term?

A It's a fetus that is viable, that has a heartbeat, that has – it is undergoing normal genetic or normal embryonic development.

Q By viable and what you just said, do you mean after the point of viability?

A No. I mean, at that given moment, not that it – I don't necessarily mean that it's going to go on and live. We don't know that, but a pregnancy, I think at 10 minutes after conception, you have two cells that are living or one cell as they combine.

Q I want to return now to your summary of the methods you [p. 91] use to perform abortions and ask you to describe those in some detail one-by-one. Let's start with the early procedures you do. Let me start with the one you described, Methotrexate and –

A Methotrexate and Cytotec or Mifepristone.

Q How does that procedure work?

A That is a procedure that's done on very early patients. It's usually – and there is currently a study that's being proposed to do tablets, but it's usually an injectable form of the drug Methotrexate is given after you have done an ultrasound to ascertain the exact dating of the pregnancy. Usually, the injection is given in one of the large muscles of the body, and after a period of five to seven days, the patient returns for the second ultrasound to confirm the fetus is no longer living, and at that point she uses the Cytotec tablets. We are currently using four 200-milligram tablets vaginally to promote or to cause induction, if you wish, to cause the fetus to expel the

pregnancy – I'm sorry – to cause the uterus to expel the pregnancy.

Q And then you also described the method using RU 486?

A RU 486 is a drug Mifepristone which we're currently using in a clinical setting, a clinical experimental setting, that's being conducted through the University of Rochester. Consists of one tablet of – one tablet of RU 486 and Mifepristone taken by the patient in the clinic on the first [p. 92] day. On the third day, the patient, and that, again, is after an ultrasound to confirm gestational dating. On the third day, the patient would insert the tablets Cytotec tablets at home vaginally, returning on the fourth day for an ultrasound to confirm that the abortion is complete.

Q In both of those cases, if the abortion is not complete, what do you do?

A In the case of the Methotrexate, we would, on the seventh day, if the fetus is still viable, give a second dose of Methotrexate and have the patient again return in a week. There have been some reports of people doing up to four doses. We have not done that. We have elected after the second dose, if the fetus is still living, to go ahead and do a surgical aspiration abortion.

Q Putting aside, then, these two methods of RU 486 and Methotrexate, you indicated you also do a suction aspiration?

A A vacuum aspiration.

Q A vacuum aspiration. Can you describe what you do in a vacuum aspiration procedure?

A Again, and I didn't go into the preoperative portion of both of these, the medical and the surgical, but we have a rather extensive patient advocate session where we describe the procedure completely and review the patient's options. We do laboratory testing to show her that they are a candidate, if they don't have other medical reasons that [p. 93] would preclude doing an abortion at that time. We do ultrasound to confirm gestational dating, and subsequent to that, we use a local anesthetic to numb the cervix. We use a series of progressively increasing dilating rods to enlarge the cervix, and then we use the plastic, in my case, I use plastic, but there are metal cannulas available to insert through the cervical os, and when attached to a vacuum machine, cause the contents of the uterus to pass through that tube. Following that we use a sharp curettage to clean the uterine wall, and we reaspirate following that, and then the patient goes to recovery.

Q What would be the latest stage in pregnancy that you would use the procedure you just described?

A In the 14th to 15th week. Most of the time by the 15th week, it doesn't work. I always start that way in 14 or 15 weeks, but most of the time, you have to use a mechanical forcep to actually grasp the fetus and remove it.

Q Now, talking about the ones where you are doing only that procedure, the vacuum aspiration procedure, do you use ultrasound while you're conducting the surgery?

A Yes, sir, I do.

Q Can you describe for the Court what ultrasound is?

A It's an adaption of the sonar developed by the Navy in the 1930's to find the different densities of substances, usually in comparison with a known substance. In our case, [p. 94] we are looking for air, fluid, and the main substance we are comparing to is water. The other fluids are fetal tissue, fetal cartilage, and we are comparing the densities of that to actually graphically present a picture of the fetus on a television screen.

Q When you're doing the vacuum aspiration procedure, can you see the television screen that displays that graphical image?

A Yes, sir, at all times.

Q And does it show only the fetus or a larger picture?

A It shows approximately a five, five-by-six-inch area of the pelvis. If the fetus is large enough, it's only the fetus. If it's an early pregnancy, then you would see surrounding. You can move it to see any portion of the pelvis you want or any portion of the body, you can do ultrasound. You can use the same machine to do ultrasound on testicles, ultrasounds on breasts, on the heart, on the liver. It just shows you a given area.

Q In a vacuum aspiration procedure, when you begin the procedure, are you able to determine whether the fetus is alive?

A Yes, sir. We do that – Well, we do it because the patient needs to know if she is coming to the clinic with a fetus that is not alive, most – It's a monetary interest to

the patient because most of the insurances will cover a D & C [p. 95] that remove a dead, terminated pregnancy that spontaneously terminated, so we feel it's important that the patient be aware of that, and we also will often let the patients go, especially if they are on [sic] medicaid where they can receive this charge for free at a local hospital through their own provider, we'll allow them to go back and see that provider. I think it's really in their best interest to know if the fetus is alive or dead. If the fetus is alive and it's within our gestation, again, we would continue.

Q As you're doing the vacuum aspiration procedure, can you determine – Well, first, do you remove a substantial portion of the fetus vaginally during vacuum aspiration?

A We remove all the fetus either intact or just dismembered.

Q How do you decide, or how is it determined whether it's intact or dismembered?

A It's whatever, when it comes through the tube. I have no – I have no governing effect on that.

Q What I mean is, can the whole fetus come through the tube, through the suction tube?

A If the fetus, if you are using – if we feel the fetus may warrant using a 9 cannula, a fetus was a little bit smaller than that, it could come through intact without disruption.

Q Could you describe for the Court, please, I don't know [p. 96] what this terms means either. What is a cannula?

A The cannula is the tube the plastic curette that we actually insert into the uterus through the cervical os tube to end the pregnancy.

Q Does that come in different sizes?

A They come in one millimeter size differences from four millimeters, that we carry in our clinic from five millimeters up through 16 millimeters.

Q So if that tube is sufficiently – If it's larger than the fetus, the fetus may just be sucked out in one piece?

A That's correct, and during the very early terminations, if you use the manual aspirators which are available, then you're using a size six or seven aspirator or a three- to four-week pregnancy, they almost invariably come out intact.

Q At what point in that vacuum aspiration procedure is the fetus killed or does the fetus die? Does it happen before you begin the procedure?

A No.

Q Can you identify the point at which it dies?

A Well, we use a – in our bottles that collect the specimens, we use a tissue that's – I mean, we use a substance that detoxifies blood which kills all living cells, so once it arrives in that bottle, I would say that it dies very rapidly, but I think in the journey through the tube and through the tubing and the machine, not knowing if or when it [p. 97] died, I do know of physicians that have testified and physicians that have stated, and I have seen films of – or where they have done the studies, and they

can actually show a viable fetus at six or seven weeks when it's outside of the body.

Q Again, by viable fetus, you mean –

A Actually, currently living fetus.

Q Rather than able to survive.

A It's absolutely not able to survive, but for a few seconds it could have a heartbeat or have other functions outside of the body.

Q Do you have an opinion about whether the partial-birth abortion law that we're talking about covers the type of procedure you're describing, the vacuum aspiration procedure?

A I think it absolutely does because the entire fetus has to be a substantial portion of the fetus, and it is coming through the tubing alive in many circumstances.

Q Let's talk about the type of procedure you do after you can no longer do the vacuum aspiration procedure. Tell me how that procedure works.

A The initial phases, initial portions are all the same up through the lab work, the ultrasound, and the actual injections to numb the cervix. At that point, we would still dilate as we would for a mechanical procedure up to, depending on the gestation, up to approximately 16 to 17 [p. 98] millimeters in diameter. At that point, we would put an osmotic dilator, which is a small piece of, in actuality, of seaweed that has been sterilized and prepared medically so that it was sterile. We would coat that with an antibiotic solution or antibiotic ointment, place those in the cervix. At that point, the patient would wait

generally 12, sometimes up to, depending on the gestation, from 12 to 72 hours before we would complete the abortion, and by completing the abortion, the patient would go home, or if they lived more than – We would like them to be within an hour, but we require them to stay within at least two hours of the clinic so if there was an emergency they could get back. When they return, we remove the laminaria. If the dilation is adequate, we would go ahead and rupture the membranes and then remove the fetus mechanically. Following the fetal removal – the fetus, removal of the fetus and the placenta, we would vacuum aspirate to make sure no tissue fragments are left on the uterine wall, and we would also use a sharp curettage to clean the uterus, and then the patient would go to recovery. If the patient were over 19 weeks, or if the patient did not dilate well, we might remove the laminaria we had put in and place new laminaria, or we might simply add a few additional laminaria and use Cytotec tablets to help the uterus start to dilate. It's a Prostaglandin.

Q You mentioned at one point laminaria. And I just wanted [p. 99] to be clear for the record, can you tell me, is laminaria the same as the seaweed?

A Laminaria japonica is the type we use.

Q When you described the woman leaving your office after she has a laminarius inserted and staying within one or two hours, is she able to carry on her normal activities during that time period, or are there specific restrictions?

A There are restrictions. We would restrict them, we would suggest restrictions. I'm not sure they are always

carried out. We would like them not to have any sexual activity. We would like them not to engage in any physically demanding strenuous work. We ask them to try to keep driving to a minimum. In fact, we ask them not to drive at all because they are also receiving medications to help with pain relief, so they are instructed not to drive at all. We do have – We have had patients that would go back to work and work the rest of that day and work part of the next day before they came in if their work was desk work.

Q When you do what you described as the mechanical removal of the fetus for these later abortions, is that also done with ultrasound?

A Yes, sir, it is.

Q So again, you can see graphically the picture of the fetus and surrounding area?

A Yes, sir.

[p. 100] Q Tell me in more detail how you go about mechanically removing the fetus.

A Once we're certain that we have adequate dilation, we either use the vacuum aspirator to rupture the membranes or use a forcep to rupture the membranes. And occasionally, the membranes that surround the fetus and hold the bag of water will spontaneously rupture before the patient gets into the procedure room. Once the membranes have been ruptured, anything over 15 weeks, our intent is to try to remove the fetus as intact as possible, and we do that mechanically with either a Beier forcep which is a – looks like a specialized pair of pliers,

long-handled that can reach inside of the uterus to grasp a portion of the fetus and to bring it out of the uterus.

Q At that time when you begin that procedure, let's say, for example, at 16 or 17 weeks of gestation, do you know whether the fetus is alive when you begin the procedure?

A Up through – up through the 19th week, it's invariably alive.

Q How can you determine that it's alive?

A Well, on our – We use ultrasound. We always do a fetal heart rate before we do a second trimester procedure. It's documented on our laminaria forms of the fetal heart rate, at the beginning and also at the end of each time the patient comes into the procedure room through the serial dilations, [p. 101] and then we again check fetal heart rate prior to starting the final removal of the fetus.

Q You indicated that your intent is to try to remove the fetus as intact as possible?

A Yes.

Q Can you tell me why that is your intent?

A Well, I think statistically from the literature I've read, and from my comment talking with other people that do the later abortions, the number one – not the number one – probably the number three factor in lowering maternal complications is to eliminate sharp fragments, either pieces of long bone or pieces of skull fragments, from passing through the cervical os without some kind of covering or protection. When you remove

them intact, the bones are covered by the fetal tissue. It's less traumatic to the cervix. I think the other two important things that we do to reduce complications is to try to evacuate the contents of the brain directly outside of the uterus because I believe that one of the second, probably most common cause of maternal death or maternal complications, is DIC or disseminated intravascular coagulopathy. Fetal brain tissue is thought to be one of the most seriously implicated factors that cause maternal DIC, that fetal brain tissue being absorbed through the uterine wall into the blood stream causing her own coagulation factors to stop working, and I [p. 102] think the most serious or the most common cause of maternal death or complications, severe maternal complications today is amniotic fluid embolus, and that's our intent to drain the amniotic fluid before we start the procedure in order to use the evacuation procedure to hopefully remove all the amniotic fluids before we remove the fetus.

Q You indicated that you try to remove the contents of the – I think you said of the skull or of the brain?

A Remove the brain or the contents of the skull, yes.

Q And I think you said outside the uterus. I wasn't sure. At what point were you trying to do that during the procedure?

A I try to do it when the skull, when the skull is reachable through the cervical os.

Q Where is the rest of the fetal body at that point?

A It may be entirely behind the fetus inside the uterus, or it may be entirely out of the uterus in the

vaginal cavity, depending on the way the fetus was in presentation.

Q So do I understand you that if the fetus happens to be feet first, that's how you would remove it?

A Yes.

Q And if it happens to be head first, you would remove it that way?

A That's correct.

Q What specific ways do you use to decompress the skull? [p. 103] I will rephrase it. Can the skull fit through the cervix?

A If you have adequate dilation, yes, the skull can fit through the cervix. The skull is the largest dieter [sic, diameter] object that has to come through the cervix. I think that you reduce complications to the mother by having – I think – well, first of all, you reduce them by having enough dilation to do the procedure, but as little dilation as possible also helps to reduce other maternal complications such as incompetent cervix at a later date, so we would like to have the cervix large enough for the tissues of the fetus to pass through, but the fetal skull is often twice that big in diameter, so we would like to reduce the diameter of the skull to the point that it can come through that – the os, too, and our dilation, normally, that's what our dilation – We are looking for a dilation that's large enough to allow the pelvis and allow the parts to pass through compressed, granted, but not fragmented.

Q How would you compress the skull?

A Compress the skull using forceps, but if you compress the skull using forceps totally, then the skull will rupture at some point. Some of the tissue will come out of the uterus, but most of it will go in behind, if the skull – if the fetus is feet first, most of it is going to rupture through the upper portion of the skull and go into the uterine and be in the uterine cavity at which point it can be [p. 104] absorbed.

Q So is there an alternative to crushing the skull that you use?

A We use a sharp object to either tear or perforate the skull in some position so that we can put a cannula in and remove the cranial contents.

Q So you both you would use both alternatives, crushing the skull sometimes, sometimes evacuating the contents of the skull?

A Yes, sir.

THE COURT: Pardon me, counsel. It's now about 12:00 o'clock. Give me a sense of how much longer you will be. I'm simply, I guess, asking directly whether now would be a good time for our break.

MR. HELLER: I think it would be a fine time. I think I probably have approximately an hour of additional questions.

THE COURT: All right. Let me hear from the defendants. Would now be a good time for our break?

MR. SMITH: Yes.

THE COURT: All right. Let's take about an hour and 15 minutes and return at 1:15. Let me see

counsel at the bench, please. Pardon me, Doctor. You may step down, sir.

(Side bar)

THE COURT: Does anybody have any security concerns [p. 105] over lunch?

MR. HELLER: My concern is only that there were protesters out front as we approached this morning. They were rather vocal in their remarks to Dr. Carhart, "Murderer," things like that. So I'm just a little bit concerned about his leaving the courthouse and who is going to be out there when we leave.

THE COURT: Okay. Anybody else have any security concerns?

MR. GRASZ: I don't.

THE COURT: Okay. You want to go to lunch someplace outside the building, I take it?

MR. HELLER: Well, yeah, probably nearby. Is there a place nearby?

THE COURT: I'll tell you what I do. I order lunch in from a deli place, and my office can order for all of you if you want to do something like that. Otherwise, I don't know where people normally eat. Let me ask my law clerk. I don't know if you go to lunch.

MS. REMPE: There are several places close by within the block here. There is a pizza place.

MR. HELLER: Any of those would be fine. We can probably walk.

THE COURT: Is your preference to go out?

MR. HELLER: I think probably it is for a little [p. 106] while.

THE COURT: Okay. Would any of you have any objection if I had somebody from the marshal service take Dr. Carhart out through the east [sic] entrance? We have a garage entrance. Would any of view [sic] any problem with that?

MR. HELLER: No, we have no problem [sic] that. I think he would probably feel a little safer if we did that.

THE COURT: We can't provide you security outside the building, but we can give you an entrance.

MR. HELLER: The rest of us can meet him at the outside, I suppose.

THE COURT: Well, you all can go with the marshals, all of you can go, but coming back is going to be a problem because I can't have a marshal sitting there, and so you're going to have to come back through the east side.

MR. HELLER: There was – I'm not sure if it was a marshal or security guard out front.

THE COURT: There is, and there should be extra police protection out there, but folks are entitled to do what they want on the sidewalk, so if you exercise this, my point is you're going to have to come back through the east door.

MR. HELLER: That's fine.

THE COURT: I will ask you, Ms. Rempe, to take counsel and anybody who wants to go and parties to the

[p. 107] marshal service and tell them I would like to have one of the CSO's or the marshals let them go out the north door. In fact, you can take them out the north door. Why don't you just take them out?

MS. REMPE: Okay.

THE COURT: Do you know where the north door is?

MS. REMPE: We'll be going down the elevators.

THE COURT: Take them down the back. Why don't you walk down?

MS. REMPE: The stairs?

THE COURT: Yeah. That will get you out to the north door. You'll have to come back in the east door.

MR. HELLER: Thank you, Your Honor.

THE COURT: We'll see you at 1:15.

(Recess from 12:05 to 1:17 p.m.; all parties present)

THE COURT: Counsel, you may proceed.

BY MR. HELLER:

Q Thank you, Your Honor. Dr. Carhart, before we took a recess for lunch, we were talking about the procedure you used in the second trimester or procedures you used in the second trimester, and you were talking about a procedure that involved an effort to remove the fetus intact and then reducing the size of the skull so it could come through the cervix. You had identified one advantage of that procedure was something having to do with bones or bone fragments?

[p. 108] A Yes, sir.

Q Are there any other advantages to that procedure that you believe exist?

A Other than the bone fragments, the tissue fragments itself, the skin also, when you macerate the skin, it also has a propensity to release anticoagulants in the maternal circulation. Just the less instrumentation, if you can grab one part or two parts and remove the fetus, then you're not making multiple attempts to go back in the uterine cavity. Even with ultrasound, you're still partially blind. You've got two axis to see. You don't have a third so you can grasp a portion of the uterine wall, you can do damage to maternal structures.

Q Do you have an opinion about whether performing an intact D & E is safer than performing a D & E that is not intact?

A In my practice, the way I do it, I think it's much more safe.

Q Are there times when you don't remove the fetus intact?

A Yes, sir.

Q Can you tell me about that, when that occurs?

A That occurs when the tissue fragments, or frequently when you rupture the membranes, an arm will spontaneously prolapse through the os. I think most – Statistically, the most common presentation, we talk about the forehead or the [p. 109] skull being first. We talked about the feet being first, but I think in probably the great majority of terminations, it's what they would

call a transverse lie, so really you're looking at a side profile of a curved fetus. When the patient – the uterus is already starting to contract and they are starting to miscarry, when you rupture the waters, usually something prolapses through the uterine, through the cervical os, not always, but very often an extremity will.

Q What do you do then?

A My normal course would be to dismember that extremity and then go back and try to take the fetus out either foot first or skull first, whatever end I can get to first.

Q How do you go about dismembering that extremity?

A Just traction and rotation, grasping the portion that you can get ahold of which would be usually somewhere up the shaft of the exposed portion of the fetus, pulling down on it through the os, using the internal os as your counter-traction and rotating to dismember the shoulder or the hip or whatever it would be. Sometimes you will get one leg and you can't get the other leg out.

Q In that situation, are you, when you pull on the arm and remove it, is the fetus still alive?

A Yes.

Q Do you consider an arm, for example, to be a substantial portion of the fetus?

[p. 110] A In the way I read it, I think if I lost my arm, that would be a substantial loss to me. I think I would have to interpret it that way.

Q And then what happens next after you remove the arm? You then try to remove the rest of the fetus?

A Then I would go back and attempt to either bring the feet down or bring the skull down, or even sometimes you bring the other arm down and remove that also and then get the feet down.

Q At what point is the fetus – does the fetus die during that process?

A I don't really know. I know that the fetus is alive during the process most of the time because I can see fetal heartbeat on the ultrasound.

THE COURT: Counsel, for what it's worth, it still is unclear to me with regard to the intact D & E when fetal demise occurs.

BY MR. HELLER:

Q Okay. I will try to clarify that. In the procedure of an intact D & E where you would start foot first, with the situation where the fetus is presented feet first, tell me how you are able to get the feet out first.

A Under ultrasound, you can see the extremities. You know what is what. You know what the foot is, you know, what the arm is, you know, what the skull is. By grabbing the feet [p. 111] and pulling down on it or by grabbing a knee and pulling down on it, usually you can get one leg out, get the other leg out and bring the fetus out. I don't know where this all the controversy about rotating the fetus comes from. I don't attempt to do that. I just attempt to bring out whatever is the most proximal portion of the fetus.

Q At the time that you bring out the feet in this example, is the fetus still alive?

A Yes.

Q Then what's the next step you do?

A I didn't mention it. I should. I usually attempt to grasp the cord first and divide the cord, if I can do that.

Q What is the cord?

A The cord is the structure that transports the blood, both arterial and venous, from the fetus to the placenta and from the placenta back to the fetus, and it gives the fetus its only source of oxygen, so that if you can divide the cord, the fetus will eventually die, but whether this takes five minutes or 15 minutes and when that occurs, I don't think anyone really knows.

Q Are there situations where you don't divide the cord?

A There are situations when I can't.

Q What are those?

A I just can't get to the cord. It's either high above the fetus and structures where you can't reach up that far. [p. 112] The instruments are only 11 inches long.

Q Let's take the situation where you haven't divided the cord because you couldn't, and you have begun to remove a living fetus feet first. What happens next after you have gotten the feet removed?

A We remove the feet and continue with traction on the feet until the abdomen and the thorax came through

the cavity. At that point, I would try – You have to bring the shoulders down, but you can get enough of them outside, you can do this with your finger outside of the uterus, and then at that point the fetal – the base of the fetal skull is usually in the cervical canal.

Q What do you do next?

A And you can reach that, and that's where you would rupture the fetal skull to some extent and aspirate the contents out.

Q At what point in that process does fetal demise occur between initial remove – removal of the feet or legs and the crushing of the skull, or I'm sorry, the decompressing of the skull?

A Well, you know, again, this is where I'm not sure what fetal demise is. I mean, I honestly have to share your concern, Your Honor. You can remove the cranial contents and the fetus will still have a heartbeat for several seconds or several minutes, so is the fetus alive? I would have to say [p. 113] probably, although I don't think it has any brain function, so it's brain dead at that point.

Q So the brain death might occur when you begin suctioning out of the cranium?

A I think brain death would occur because the suctioning to remove contents is only two or three seconds, so somewhere in that period of time, obviously not when you penetrate the skull, because people get shot in the head and they don't die immediately from that, if they are going to die at all, so that probably is not sufficient to

kill the fetus, but I think removing the brain contents eventually will.

THE COURT: Counsel, once again, and just so we're all playing on the same score card, so-to-speak, I suppose that we can debate what fetal demise means, and I understand the doctor's statement. It might be helpful to talk about lack of heart function, lack of brain function to the extent you all think that's important. I think that will clarify the record. Those are typically the normal indicia of life.

MR. HELLER: Certainly, Your Honor.

BY MR. HELLER:

Q I think you've said that brain function may continue for a few seconds. I'm sorry. Not brain function, heart function may continue for a few seconds after the skull is decompressed, is that correct?

A Right.

[p. 114] Q And then the heart would stop, is that correct?

A Eventually, yes. The heart, you can take the heart out of, you know, medical school, remove the heart from dogs. They have done studies on this back into the 30's and 20's, remove the heart and do studies on the heart for several minutes on hours if you infuse it with oxygen and saline and keep the heart alive. The rest of the fetus is not innately necessary to keep the heart alive. It's just as long as the heart is going to beat until it runs out of oxygen and the cells die on its own.

Q How soon after you begin decompressing the contents of the skull would you say that the brain function ceases?

A This would be purely conjecture. I don't know of any instruments that are even made to measure that. I certainly wouldn't have the availability of any of those.

Q Certainly, the brain function doesn't continue after you have done that?

A No, the brain function doesn't, but University of Florida just reported several brain transplants from fetal tissue several days after the death – after the termination of the pregnancy into humans, and they are showing response to that living fetal tissue, so the cells may not function as a brain, but that doesn't mean the cells are not living.

Q Well, in terms of brain function, the brain has ceased to function very quickly after you begin the – removing it?

[p. 115] A I guess I don't know that anybody can tell you what the brain does in a fetus. I mean, we can find some brain waves. There is no good evidence that they represent anything. All the movements in the fetus from – do not correlate to brain waves, but the movements the fetus does are thought to be unintentional and more reflex, reflexive and probably at the spinal cord level rather than the brain cord, the brain tissue level, so I don't know how to answer that.

Q Now, are there situations where you set out not to do – to remove the fetus intact but to remove it by dismemberment, or is your intention always to –

A I think my intention after the 16th week is always to remove it intact. I think that my actual success in doing that is probably, up through the 19th week, less than five or 10% that actually come out totally intact.

Q Why is that?

A I think because of the softness of the tissue where the tissue is easily fragmented, and again, I don't feel the need to push the arm back up or try to turn the fetus to get the feet out first. I think you have to take advantage of whatever presentation you have and reduce the size of the fetus as much as possible and remove it. I'm sure you could do more dilation, and you could remove all of them intact if that were your goal, but I don't – I'm looking for a solution that's the best all around for the mother. I mean I [p. 116] –

Q When you are doing a D & E that involves dismemberment, where does the dismemberment occur; in other words, do you insert instruments into the uterus and dismember the fetus inside the uterus, or do you dismember it in some other way?

A Well, we insert one instrument inside the uterus, grab a portion of the fetus and pull it through the cervical os. The dismemberment occurs between the traction of – I'm sorry – between the traction of my instrument and the counter traction of the internal os of the cervix. I suppose you could put two instruments in the uterus and try to dismember it. I think that would be very dangerous.

Q So the dismemberment occurs after you pulled a part of the fetus through the cervix, is that correct?

A Exactly. Because you're using – The cervix has two strictures or two rings, the internal os and the external os, and you have – that's what's actually doing the dismembering. It's like who is pulling the cat's tail. If you are holding it and the cat's pulling it, something has to pull the other way. Otherwise, if you drag a string across the floor, you'll just keep dragging it. It's not until something grabs the other end that you are going to develop traction.

Q When we talked before or talked before about a D & E, that is not – where there is not intention to do it intact, [p. 117] do you, in that situation, dismember the fetus in utero first, then remove portions?

A I don't think so. I don't know of anyone that – I don't know of any way that one could go in and intentionally dismember the fetus in the uterus. If you grab an extremity and twist it, you can watch the whole fetus just twist. It takes something that restricts the motion of the fetus against what you're doing before you're going to get dismemberment.

Q When you pull out a piece of the fetus, let's say, an arm or a leg and remove that, at the time just prior to removal of the portion of the fetus, is the fetus alive?

A Very often, yes, sir.

Q And after that, when does fetal demise occur in that type of abortion?

A I think the fetus is going to lose blood the same as an adult would or a child would if it loss an extremity, but how fast that is going to happen, I don't know that I can comment on. I don't know any way you could study

that, and I don't know how many – how many minutes or how many hours the fetus could continue to lose this blood. The fetal blood supply is certainly much greater than the adult or the children's blood supply because they have got a blood supply both in the fetus and in the placenta, so it's going to take a considerable amount of blood loss before the fetus is going to, you know, [p. 118] have an insufficient amount to profuse. I don't think there is any way to determine that. I mean, we could – I could do it by watching the monitor. I'm not – There has been one case in New York that a physician lost his license over - when he removed the arm of the fetus, and that fetus eventually went on and was born-as a living child with one arm, so I don't think you can say that necessarily will cause death.

Q Well, when you do a procedure and you remove an arm, what do you do next?

A Just continue removing whatever else you can get a hold of.

Q At some point during the removal of portions of the fetus, does the fetus die? In other words, you remove, let's say, a leg or an arm, then you remove some other portion of it. At some point, is the fetus – Does the fetus undergo demise, do you think?

A As a unit –

Q Well, let's talk about it as a unit, a functioning unit.

A Well, as a unit, I would think there is some point that the loss of the extremity is going to be so great that the fetus will die. That may well take longer, though, for

all heart functions to stop. We are only talking, for some of these patients, a procedure that lasts four to five minutes. Heart function certainly can continue more than four to five [p. 119] minutes.

Q Have you ever removed a portion of a fetus and observed heart function on ultrasound?

A While we are removing it?

Q After removing it or during.

A I have never done an ultrasound on the fetus afterwards, no, but while the fetus is in the canal and you're removing the fetus through it, we can still see fetal heart activity with extensive parts of the fetus removed.

Q Do you ever try to induce fetal demise before beginning surgery?

A Yes.

Q Under what circumstances do you do that?

A I usually try to do this on all of my patients after the 20th week of menstrual gestation.

Q What method do you use to induce fetal demise?

A I use an ultrasound guided much like amniocentisis and intrafetal – or hopefully an intracardiac fetal injection of Digoxin and Lidocaine.

Q What do those substances do?

A Both of those substances reduce and stop cardiac activity.

Q How long after administering those substances do you perform surgery?

A Normally not for 48 to 72 hours.

[p. 120] Q Is there an advantage to doing that? To –

A I feel multiple advantages. First of all, it's comforting for the woman to know that the fetus is already dead. I think that gives some mental – It's an end point to the procedure that she's not living with for two or three days. I think the second thing it causes is, there have been some very good studies of people that have divided the cord on fetuses and caused fetal demise and waited 24 to 48 hours for these patients to do the last part of the procedure, and the tissues become very soft, and they become very malleable, and the brain plates will overlap. You can do much less dilation. We have been keeping some numbers or we'll see an actual loss in measurements of the fetal skull up to two weeks over that 72 hours. We are supposed to get four, five or maybe even a six millimeter decrease in biparietal diameter because of the loss of water from the fetus and then from the loss of the mush, mush factor. I don't know what else to call it by the softness of the tissue that compresses just from the maternal contractions.

Q Why would you not use Digoxin and Lidocaine to induce fetal demise prior to 20 weeks?

A I have – I initially started doing it on everyone over 16 weeks. My findings were that it really was not that beneficial because in the 16- to 20-week time frame we're only waiting 12 to 24 hours to go on with the second part of [p. 121] the procedure so that, really, fetal death had occurred but not much a change to the tissue had occurred, and the risk, there was a trade-off with the maternal comfort from the fact the fetus was dead. There

is a trade-off of the great apprehension and fear that most women have of having an amniocentesis done, let alone when they know their fetus is going to die from it. There is a mental you know, most of my early patients. The later patients seem to be very thankful, but the patients in the 15-, 16-, 17-, 18- and even 20-week range are more afraid of – just were asking if they could avoid that. We finally, we'll do it if they ask us to do it. We sort of tell them it's available, but we don't normally do it.

Q Is there any medical reason not to do it earlier than 19 or 20 weeks?

A Yes, there is. The reason why saline induction was originally in the early 60's and the 70's were limited to after the 18th and 20th week. You have problems of perforating bowel, you have problems from needle penetration. As the uterus enlarges, it pushes all these structures out of the way, and there is less chance of causing maternal complications, but under that, before the 20th week, I don't necessarily – I don't think that is true. I think there is more likelihood of putting the needle through a loop of bowel or as the uterus is smaller, you have a much smaller target [p. 122] and you have more of a chance of getting the medication into the maternal circulation than you do into the fetal circulation.

Q Why is that?

A Well, we are using two drugs that are – is the maximum recommended dose for an adult woman of a hundred pounds, and that's why it's not toxic to her. If the entire amount of the drugs were injected into her blood stream, it would not be toxic, probably, if they had no other side effects, no other medical problems, so that's

why I use the dose that I do use. That dose is toxic to the fetus. But there is always a chance of getting into, say, the cord, getting into the placenta, or maybe even getting into the uterus itself, and as I said, we are dealing with a two-dimensional picture trying to, in our mind, to determine where the third dimension is, and if you get through the placenta, through the fetus into the posterior uterine wall, then the mother can get all of the side of effects from the Digoxin or all of the side effects from the Lidocaine.

Q Do you ever see patients who for whom those Digoxin and Lidocaine are medically contraindicated?

A Yes, sir. Patients who have seizure disorders, patients who have heart disease, possibly already on Lidocaine – already on Digoxin as a maximum level, they already have received the maximum dosage of that medication they can. You [p. 123] can't – I can't take the risk to use that medication for them.

Q And that would be even if they are after 20 weeks?

A Anytime, yes, sir.

Q So in those instances, you can't really induce fetal demise?

A No.

Q We were talking about intact D & E before. Have you ever had a patient request that the abortion be – result in intact fetus?

A I have, and I will tell them much the same as I tell the people that request that we we don't do that, is

that I will try to honor their wishes, but I can't compromise their safety and do something that is more dangerous in order to have that as the end goal.

Q What – And what – Have patients indicated to you their reasons for wanting it intact?

A We have patients that occasionally ask to have their fetus buried through a funeral parlor, to have services. Both people, I mean, even gestations where they know the that [sic] fetus is probably not going to be intact we have had them request that. Sometimes for genetic studies, when the entire, the entire amount of the deformities aren't known, we'll get requests from a physician, possibly, to have the fetus as intact as possible.

[p. 124] Q I want to refer you now – Do you have the exhibits there that I gave you?

A Yes, I do.

Q Exhibit 7, and if you would turn to page 8 of that exhibit?

A Yes, sir.

Q If you would turn to the last paragraph of that page, the paragraph states – Well, do you see the paragraph that begins with, "To minimize uterine or cervical perforation?"

A Yes, sir, I do.

Q If you could read that over and tell me whether you agree with it.

A Should I read it out loud or just read it?

Q You can read it to yourself.

A Okay. Can you repeat your question?

Q Well, let me ask you more specific questions. Do you agree that as this statement says, "That some physicians use a form of D & E that has been referred to in the popular presence intact dilation and extraction." Do you agree that some physicians do that?

A Yes, sir, I would.

Q Do you agree that they do it in part to minimize uterine or cervical perforation?

A Yes, sir, I would.

Q Do you agree that the D & X procedure may minimize [p. 125] trauma to the woman's cervix uterus and other vital organs?

A Yes, sir.

Q Earlier we talked about other second trimester procedures, and you mentioned inductions. You testified that you don't do inductions in second trimester. You do procedures earlier that might be called inductions. Why don't you do inductions in second trimester?

A Well, to do a classical induction would require – Well, first of all, it would require the patients to stay longer. An induction, you don't know where the end point is going to be. You're at the – at the, I guess, totally under the control of the cervix, when it's going to release. I had - An associate had a patient in one of our Omaha hospitals in '92 that was 19 weeks pregnant with – I'm sorry – a pregnancy with a 19-week gestation, was

severely, had severe fetal flaws, and their hospital would only allow induction. He attempted to induce her for a period of over a week. Subsequently, they ruptured membranes, and still, the patient did not deliver, and subsequently she ended up having hysterotomy and a total hospitalization of over two weeks. It's, to me, induction by itself is too uncontrolled. There is no finite end point, and women have reactions to the drugs. The number of people that you can't use for induction because of hypotension or heart disease or diabetes, it's a large segment of the population where it wouldn't be [p. 126] available to them.

Q Are you aware of physicians in Nebraska who perform abortions by induction?

A Yes, sir.

Q Where do they do that? At what facilities?

A The facilities I'm aware of are Bergan Mercy, University of Nebraska, and Methodist.

Q Methodist Hospital?

A Yes, sir.

Q If a woman wanted an abortion by induction, would you then refer her to one of those places?

A I couldn't refer her to the hospital in any of those instances. I can't refer her to the University of Nebraska because they are restricted. They can only do – they can only do terminations on women that have – that have pregnancies that are so severely flawed they cannot survive through delivery. And I strongly – I think I believe

strongly enough that induction is not or is actually contraindicated in abortions that I would not make the referral. I would tell them of the places or the people that they could see if they wished to pursue it on their own, but I would not make the referral.

Q If an induction does not result in termination of the pregnancy, what is done to complete the abortion?

A You have the option of either doing osmotic dilators and [p. 127] doing the abortion that we would classically do in the two or three-day setting, or the hysterotomy which is a C-section, but because of the fact that the uterus is not large enough, you can't do the safe C-section where it would be a low transverse C-section and allow the woman to have future pregnancies that she could deliver. You have to do a midline upper third incision into the uterus, and that condemns her to C-sections for all her future deliveries.

Q Are you aware of any induction being performed in outpatient clinics in Nebraska or in doctor's offices?

A I'm not.

Q Again, I'm talking about second trimester abortions.

A I'm not aware of any. I'm sure it's happening somewhere in the country. I think I know everybody in Nebraska that's doing abortions, and I'm not aware that any of them do them in their office.

Q Do you perform hysterotomies as a method of abortion?

A No, sir.

Q What about hysterectomy?

A No, sir.

Q Are you aware of any physicians in Nebraska who perform abortions by hysterectomy or by hysterotomy?

A Yes, sir. I know they have been done in Nebraska.

Q Do you have a copy of Exhibit, I believe, 11 or 12? Do you have either of those there?

[p. 128] A I have both 11 and 12.

Q If you could look at Exhibit 11, is there a cover page on Exhibit 11, or is it just one page?

A There are –

Q Three pages?

A Yeah, three sheets of paper. One is double-sided.

Q If you look at the second piece of paper, can you identify that?

A This is the current Nebraska State Department of Health reporting form.

Q Is that the form you use to report abortions?

A Yes, sir, it is.

Q Currently?

A Yes, sir.

Q Does that form contain a space on which you can indicate the method of abortion used?

A Yes, sir, it does.

Q Can you tell me what methods are listed there?

A Paragraph 14 says types of procedure performed that terminated pregnancy. Choose one. Suction curettage, medication-induced, specify. Dilatation and evacuation, sharp curettage, dilatation and excision, and other.

Q The one prior to other dilatation and excision, are you familiar with that as a procedure for doing abortions?

A No, sir, I'm not.

[p. 129] Q So do you when you do an intact D & E or what we have also called an D & X, how do you report that on this form?

A On this form, we are doing it under block number three.

Q What is block three?

A Dilatation and evacuation, D & E.

Q Which exhibit are we on on that?

A We were on page number 2 of Exhibit 11.

Q If you could now look at Exhibit 12?

A Yes, sir.

Q Can you identify that document?

A This is the form that was used, at least back through 1988, that I'm aware of in the State of Nebraska.

Q And did that form include a section where you could indicate the type of procedure used?

A Yes, sir, it does, under section 8a.

Q And what types of procedures are listed there?

A Suction curettage, sharp curettage, intrauterine saline installation, intrauterine Prostaglandin installation, hysterotomy, hysterectomy, and others.

Q Where on that form would you have indicated that you did either a dilatation and evacuation or a D & X abortion?

A Under suction curettage.

Q That's because that's the one that best fits?

A I think that's the one that fits the most.

Q On the newer form, is hysterectomy or hysterotomy listed [p. 130] as a method still?

A I don't believe it was. Just other, I think you would have to specify in there.

Q If you faced prosecution for performing any D & E procedure, whether the fetus was alive, what would the impact be on your patients?

A If, by facing prosecution, you mean if I could change my practice and not become prosecuted?

Q Let me rephrase the question. If you faced prosecution for performing D & E procedures, what would your options be?

A Okay. If I knew that I would be prosecuted if I did the D & E the way I'm doing it now, I would stop

doing them the way I'm doing them now. I think the options would be to probably stop doing abortions between the 7th week and the 18th week because I think that I would be totally safe doing the medical procedure where we're sure the fetus is dead before it is expelled, and I think I would be safe during fetal injection which I, in my own mind, I think I could safely bring down to the 19th week. In the hiatus between the 7th week and the 18th week, I think I would refer them to another state or tell them that they would need to delay, which I don't think I would recommend to anyone.

Q Now, if, instead, you knew that instead of removing the fetus intact or trying to remove the fetus intact, instead, you had to avoid doing that and just try to remove it in [p. 131] pieces, what impact would that have on your patients, the switch from intact procedure to the nonintact procedure?

A I think to intentionally bring sharp pieces of bone and sharp pieces of fetal skull plate through the cervical os is to ask for an increase in incidents in maternal complications, and I don't think that that is a wise judgment.

Q If you were –

A Can I add one? Then also by doing that, we go back to the other factors of having macerated skin tissue and macerated fetal brain tissue within the uterine cavity to be absorbed into the maternal circulation and cause, what is right now, the most common cause of maternal death of abortion and that is disseminated intravascular coagulopathy, or, fetal – I'm sorry – maternal – embryonic fluid aspiration embolus.

Q Aside from the risks associated with sharp bones and so forth and these other two, are there any other?

A Instrumentation.

Q What's that?

A The multiple instrumentation, the chances of tearing the uterus or perforating the uterus with the instrument each time you go back in.

Q If you were in that situation you described where you would stop doing abortions between 7 and approximately 19, 18 [p. 132] or 19 weeks, would your patients be able to obtain abortions by induction elsewhere in Nebraska that you know of?

A I don't believe so.

Q Would they be able to obtain abortions by hysterotomy in Nebraska?

A I don't know people that are doing these electively. I don't know of anyone in Nebraska that's doing these for elective abortions. They are doing them for, you know, for maternal or fetal indicated abortions.

Q Incidentally, in terms of your practice, do you know if there are other physicians in Nebraska who provide abortion services as late in gestation as you do?

A I believe I'm the only person in Nebraska that goes past 16 weeks, with the exception of Dr. Jerry Smith at University Hospital, but he is restricted to only doing abortions when the woman's life is in danger. Well, that's not true because he refers those to me. I can only do them when the fetus is so severely flawed that it cannot live to deliver.

Q Do you still have a copy of the statute LB 23 with you?

A Yes, sir.

Q If you could turn again to page four of that document, section 3, around line 17, do you see that?

A Yes.

Q That section states that, "No partial-birth abortion shall be performed in this state unless such procedure is [p. 133] necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including life-endangering physical condition caused by or arising from the pregnancy itself. Do you see that?

A Yes, sir.

Q Do you see women who need abortions for mental health reasons?

A I have referrals from other physicians for that, yes, sir.

Q And what are some of the mental health reasons for abortions?

A I have to go back and clarify that. I have not had any referrals in the state of Nebraska for mental health reasons. I'm sorry. I have had for other health, physical health reasons, but not actually mental health. However, I have had patients come to me and on their comment sheets at the end write that if this option had not been available, that they would have considered killing themselves or attempting self induced – a self-induced abortion.

Q Have you seen women who want an abortion for health reasons, physical health reasons?

A Yes, sir.

Q Where the reason – where the abortion would not necessarily save the woman's life but only to preserve her [p. 134] health?

A Yes, sir, I have.

Q Can you give me some examples of that?

A Renal failure, severe renal disease. I shouldn't say renal failure. Severe brittle diabetes where they were remaining hospitalized to keep their blood sugars in reasonable control, that they were too brittle to even maintain any kind of control outside of the hospital and hyperemesis gravidarum where they constantly vomit with the pregnancy and can't keep food down and lose a good portion of their body weight are the three that come mostly to mind.

Q Do you believe that those situations would fall outside the life – the exception for partial-birth abortions necessary to save the life of the mother?

A Yes, I do.

Q So those – such women would have to use, if they wanted to end the pregnancy, some method of abortion that was not a partial-birth abortion, is that right?

A Some method that wasn't covered by this law, and I don't know what partial-birth abortion is. I can't answer that.

Q That's why I was using the term. Some method that is not covered by this law. For such patients who suffer from some sort of health problem where they would like to obtain a D & E abortion or any abortion that you believe is covered by the law, what would the effect be on them of not being able [p. 135] to get the abortion? Take the example of a hyperemesis you described.

A I think you could – We see people as early as 7 and 8 weeks for hyperemesis. We see them routinely in the 12th to 15th week, but I think they would be told that they would need to either stay hospitalized. The woman that comes to mind most recently was 18 weeks that was brought here by – She was hospitalized on IV fluids up until the time they discharge her from the hospital in Benkelman, Nebraska, and drive 10 hours to Omaha, have her procedure, and then they took her back to the hospital where she was kept on IV's for 24 more hours after the procedure. It would mean that they would continue whatever disease process they had for an extended period of time until, I think, the abortion would be possible, or it would mean that they would have to travel further to another clinic in another jurisdiction where something could be done for them.

Q If a woman had to wait until the time at which you felt comfortable inducing fetal demise, would that also increase the cost of the procedure for her?

A Increase the cost. You can take that both ways. Increases the financial cost to her. It also increases the medical risk cost, the chances of her being – having some kind of an injury or complication goes up very – I think

Dr. Henshaw said something about 10% per week after the 12th [p. 136] week, or I'm not sure what his testimony was, but the numbers do drastically change. The studies that I'm familiar with is an abortion in the earliest stages is approximately 35 times safer than the childbirth as far as all complications across the board. By the 20th week, they are approximately equal to childbirth, and to make a woman increase her risks from one out of 35 times as dangerous as having a fetus in a normal pregnancy to a number that is 20 or 30 times greater than that doesn't seem to be in their best interest.

Q Are you concerned that if this law were, in fact, you might be prosecuted under it?

A Yes, sir.

Q Why are you concerned about that?

A I guess given my relationship with the attorney general, I've already been investigated for breaking a law which had been ruled unconstitutional 15 years ago, yet he still initiated proceedings against me under that law. It was eventually, I assumed, discharged because I have never heard any further reaction, any further comments on that, but, you know, several – several sessions with attorneys took place, and a lot of money was spent, and a lot of aggravation was undergone, I'm sure, by both sides to [sic] – I don't know what to call this.

Q Do you know if there has been any or has there been effort to, by the State, to investigate the methods of [p. 137] abortion you use?

A Yes, sir.

Q And in what context did that occur?

A I believe we had a formal meeting with the State Department of Medicine. I think the month was December of '96, possibly November of '96.

Q And what occurred at that meeting?

A It was a session where myself, and I believe you and Mr. Hug were present, along with several members from the State Department of Medicine investigative board, and they reviewed my practice in-depth. It also consisted of an investigation by the Department of Medicine investigator and a Federal Bureau of Narcotics board of investigation where they did an inventory of every patient's drug use that I have had in my clinic for the past three, actually four years.

Q Do you know what the result of that investigation was?

A No, sir. I have never been told.

Q When did the federal agent come to your –

A I believe that was in the early fall of '96. I'm not sure of the exact date. Possibly August or late summer, early fall of '96, and she was brought there by the state investigator.

MR. HELLER: I have no further questions, Your Honor.

THE COURT: Counsel, you may inquire.

[p. 138] CROSS-EXAMINATION

BY MR. SMITH:

Q Dr. Carhart, concerning your testimony that you thought if you were going to be prosecuted, you wouldn't

do abortions after seven to 18 weeks; do fetuses have sharp bones at eight weeks?

A I wouldn't believe so.

Q So as far as one of the complications concerned about intentionally having sharp pieces through the cervix if you had to cut the fetus up in the uterus because of the risk of sharp bones, that really isn't true at eight weeks, is it?

A I'm not aware of any way to cut the fetus up in the uterus during gestation.

Q But at least the risk of sharp bones from the fetus perforating the uterus at eight weeks, that is not a risk, is it?

A I don't believe I stated that it was.

Q If I misunderstood you, I apologize. Are you familiar with what is known as the American Board of Medical Specialties?

A Yes, sir.

Q And would you agree that that is an organization which is authorized, it has 24 medical specialty boards which certified physicians who are practicing specialties in the United States?

[p. 139] A I agree that that part is true.

Q Okay. And are you certified by any medical specialty board?

A No, I'm not.

Q One of the medical specialty boards would be the American Board of Obstetrics and Gynecology, is that correct?

A That's true.

Q Another would be the American Board of Surgery?

A Yes.

Q American Board of Family Practice?

A Yes.

Q American Board of Medical genetics?

A I'm not totally familiar that's the exact wording, but there is a medical genetics section.

Q And you're not certified by any of those boards, are you?

A That's correct.

Q Have you ever attempted to by come [sic] certified by any specialty board?

A I completed the residency in general surgery. I never attempted to take the boards.

Q How many years have you practiced medicine?

A Twenty-five, 24.

Q And do you have hospital privileges at any hospital?

A Not at this moment.

[p. 140] Q Would you need hospital privileges to admit a patient to a hospital?

A To admit them to your own service. You would not admit them to another person's.

Q Admit to your own service would be admitting them so that you would be the treating physician, correct?

A Can I just correct – I'm not sure about my status at Midlands right now. It's in – I don't know whether – I have been able to admit patients there, but I have been notified that my privileges were terminated. Well, it's under appeal, and it's under – The hearing is next week.

Q So as we speak, there is no hospital at which you can admit and treat patients, is that true?

A That's correct.

Q And in light of – You jumped ahead. One of my questions, have you had your hospital privileges revoked at any hospitals in the past?

A Yes.

Q And how many hospitals?

A Just one.

Q Is that the Midlands Hospital?

A Yes, it is.

Q Have you ever surrendered hospital privileges at the request of the hospital?

A No.

[p. 141] Q Now, as part of your medical background, you completed a medical residency, is that correct?

A That's correct.

Q Can you explain just what a medical residency is and then the type of medical residency that you completed?

A My medical residency was in general surgery. It's an intensive training program consisting of a number of years.

Q And I take it if you would complete a residency in surgery, the purpose would be – would have been to do surgeries in hospitals?

A That's correct.

Q How long has it been since you've done a surgery in a hospital?

A April of this year.

Q Would that be at the same hospital?

A Midlands.

Q You interrupted my question, the one in which your privileges are currently, I guess, suspended.

A That's correct.

Q As far as then your practice, your practice at the present time is in a clinic setting, is that correct?

A That's correct.

Q And in which clinic or clinics do you practice?

A I practice in Bellevue, Nebraska, at Bellevue Health Center and we practice under a clinic name also at that same [p. 142] address of Abortion and Contraception Clinic of Nebraska, and I practice at a clinic in Dayton, Ohio, under the name of Women's Med Plus, and I also practice at a clinic in Cincinnati, Ohio, with the same name. I also practice in a clinic in Akron, Ohio, with the same name.

Q Is there any reason for the two different clinic names in Bellevue?

A We started out with the intention of keeping the clinic separate. When the State passed their law regarding clinic licensure, we felt that there was little need to to duplicate two clinics at the same address and two licenses, and as one clinic was simply a trading name on the other clinic anyway, the name was there, we haven't changed our stationery, but effectively, we do everything under Bellevue Health Center.

Q And who owns the clinics in Bellevue?

A Bellevue Health and Emergency Clinic, Incorporated, is a corporation.

Q Who owns the stock?

A My children, my father's estate, and my brother, and I believe that's it.

Q Who's – Are you the controlling shareholder?

THE COURT: Counsel, pardon me. What purpose is this serving?

MR. SMITH: Well, I suppose I can move on to the purpose.

[p. 143] BY MR. SMITH:

Q Who actually controls what goes on in your clinic, Dr. Carhart?

A My wife is administrator.

Q Who actually determines the medical procedures there? What I'm getting at, is it you?

A No, there is no other physician present.

Q Okay. And it would be an accurate statement there is no type of peer review at your clinic like there would be at a hospital, is that correct?

A We have, as part of the National Boards and Federation, we submit all of our statistics to them. We submit all the complications to them, we submit all the reports of our patients' evaluations to them. I think we probably have a greater peer view than the average practice in the state of Nebraska including those in the hospital.

Q Do you think you have got better peer review at your clinic than would be in the hospitals? Is that what you're saying?

A I would be happy to say that.

Q Would you agree that a hospital, the medical procedures, at least, are subject to justification by the other physicians who have privileges there?

A Yes.

Q And that's not the situation at your clinic, is it, [p. 144] since you're the only one who practices there?

A What's the situation?

Q There is no other physician that practices at your clinic other than you who determines what you can and cannot do at the clinic, is that true?

A At my particular clinic, there is no one else, but at the national level, there are other people for us to maintain our certification with them, that we have to practice within their guidelines.

Q Okay. Now, as far as the fees that you've testified to, and you broke down the fee schedule, do you know what the fees would be that you've received from performing abortions in 1996?

MR. HELLER: Objection, Your Honor. I thought this was going somewhere. I wasn't sure where, but I have no idea what possible relevance could be of the doctor's –

THE COURT: Counsel, would you tell me about relevance?

MR. SMITH: Relevance would be motivation and bias, obviously, if you have a financial interest in what you're doing.

THE COURT: How far are we going to go with this?

MR. SMITH: At least – I think it's sufficient to at least to inquire the extent of the financial interest, Your

Honor. I think I should be entitled to at least make a [p. 145] presentation of how much.

THE COURT: The objection is overruled. Doctor, you can answer if you understand the question.

THE WITNESS: Nothing.

BY MR. SMITH:

Q Do you know how much you received in fees from abortions in 1996?

A How much I personally received from abortions in 1996 as paid from the corporation?

Q Yes. Well, let me ask you, are you paid by salary?

A No, I'm not.

Q Do you know how much the corporation has received in fees?

A Actually, no, I do not.

Q And as far as, is there a figure that you know that you've received in fees from performing abortions, either directly or through the corporation?

A Yes.

Q What is that?

A Zero.

Q And where do the fees go, then, if you did not receive them?

A Right now they have gone into the developing the corporation.

Q And what do you mean by developing the corporation?

[p. 146] A Attempting to purchase the building, doing the improvements to the building, paying staff, buying equipment.

Q You are paid a salary?

A I'm not – I have not taken a salary yet from the business. My salary is from the United States Air Force retirement, so –

Q So women come in for the abortions, you do not receive any of the fees other than –

A In 1996, I did not.

Q Other than just simply the corporation acquiring assets, is that true?

MR. HELLER: Objection. Him getting fees and the corporation obtaining assets are two different things since he's not an owner.

THE COURT: Sustained as to form.

BY MR. SMITH:

Q Does the salary that is paid go to your wife then?

A My wife receives a salary for working at the clinic.

Q And I assume that goes to the family household. You live together?

A I think that it does.

Q How much does she get paid?

MR. HELLER: Objection, Your Honor.

THE COURT: Sustained.

MR. SMITH: I would like to make at least an offer [p. 147] of proof.

THE COURT: Make your offer of proof.

MR. SMITH: The offer of proof requires him to answer the question.

THE COURT: No. Make your offer of proof if you know what the answer is.

MR. SMITH: I don't know the answer, Your Honor, so I can't show what the answer would be.

THE COURT: The objection is sustained.

BY MR. SMITH:

Q Would it be an accurate statement that the fee schedule you related earlier that the amount of fees are based, in part, on the complication for the procedure?

A Can you –

Q How do you – What is the reason why, as there are more weeks advanced in the pregnancy, the fee is higher?

A The amount of effort and time, the material costs, labor costs. We're talking an investment of my time of five minutes or 10 minutes in an eight-week pregnancy as opposed to maybe 45 minutes to an hour in a 20-week pregnancy.

Q Am I correct in understanding, then, as far as doing an abortion by an induction procedure, that you do not do that at the clinic?

A That's correct.

Q And the reason being what?

[p. 148] A The reason, I believe, that the induction is a less acceptable method of abortion. I think it has higher risks, I think it has greater cost to the patient in factors other than money, and I think that the greater amount of facilities, as Dr. Henshaw testified in his testimony, the hospital cost of three to four times what the outpatient environment cost is, I'm sure the outpatient cost to provide that service would be equally the same as the inpatient cost, so there is no justification, nor is there a need.

Q Are you aware that table 4 –

A I don't have that document.

Q Do you have Exhibit 7 in front of you, the AMA report? If you do, turn to page 10, please.

A Okay. I have that.

Q Do you see that the mortality rates for induced abortion procedure is 13 weeks or later. There it shows for more than 21 weeks. It's got a higher rate for dilation and evacuation than for labor induction?

A I think I would like to direct your attention to line 2 which states that this was created in 1987, and I don't think that at all relates to the abortion industry as it is today.

Q Do you know what the mortality rate is now?

A I don't believe that has been studied. At the last reported instance that I was just published in – was – I can't exactly quote on it, but it was a review by the State [p. 149] of Texas, I believe against Dr. Chris's most recent death, and I think they published an acceptable risk at the present time of 1.5 deaths per million.

Q You would agree that the AMA, when they issued their report this year, elected to use this table of statistics that appears on the sheet?

A It appears that's what they used.

Q The ultrasound, have you used the ultrasound for the early gestation stage termination procedures where you are terminating by medication? Did I understand you correctly that you used the ultrasound during the early stage medication termination?

A I used the ultrasound in making the determination that they are eligible for that, but we don't use it during – Well, we use it to check them as they progress through, yes.

Q And the purpose for using the ultrasound for the early stage gestation procedures is what?

A To determine if the patient fits the criteria for the use of the drug.

Q Which would be what?

A Less than seven weeks, six days of menstrual dating.

Q I have a note here. Is it accurate you use the ultrasound in some method to confirm, after the administration of the medication, that the fetus is not living?

[p. 150] A Yes, sir, that's true.

Q How do you determine that the fetus is not living with the ultrasound?

A It's different. It has a different picture.

Q I mean, since that's a very young, early-age fetus, are you comfortable that you're able to determine from the ultrasound whether the fetus is alive or not?

A Yes, I am.

Q And would you agree that as the gestational age advances, that it would become easier to determine whether or not the fetus is living with the ultrasound, or does it make any difference?

A I don't see – I think that determination can be made at any gestation.

Q And when you're determining at the early stage of gestation, when you're terminating it with the medication, that the fetus is not living, how do you determine the fetus is not living; in other words, what do you mean by not living?

A The gestational sac that was present on the preceding picture has been replaced by a homogenous clot mass.

Q And is there some other method of determining the fetus is not living that you go further on in gestational stages through the use of ultrasound?

A Sure.

[p. 151] Q What is that?

A I would think fetal movement and fetal cardiac movement.

Q You can determine those by the ultrasound?

A Yes, sir.

Q And the absence of those things tells you the fetus is no longer living?

A You can – Yes.

Q Would it be an accurate statement, before you commence an abortion procedure, you would always be able to determine through the ultrasound whether or not the fetus is living or not?

A I don't think so.

Q Can you explain that?

A I think you can tell what's happening in a normal fetus because there has been a lot of data that when nothing is intervened with it, and you see a heartbeat, and you see fetal movement, that you can make the assumption that it's a living fetus. I think when you can see that the fetal tissue where there is actually no heartbeat and no fetal movement, that there has been fetal demise, but I think there is a gray area where you can often see or not see things and not be 100% sure of what is happening at that point, and I don't know how large that gray area is.

Q You understood me to ask you before you would start an abortion procedure?

[p. 152] A No. I guess you better rephrase that question.

Q My question was, before you start the abortion procedure by that process, but you would extract, remove the fetus in some manner, are you always able to tell before you start that process whether or not the fetus is alive or not?

A No.

Q Could you if you wanted to?

A I could tell you when it is dead. I can tell you when it's definitely alive. I can't tell you, I can't tell you during the interim point where it may – where the living, some of the functions have stopped and some of the other functions have not stopped.

Q Do you consider the absence of a fetal heartbeat meaning the fetus is dead?

A No.

Q Do you know if general medical standards would consider the absence of fetal heartbeat to be fetal death?

A I don't know any medical standards that determine what fetal death is. I'm not aware of a publication or anyone that has done a study to say – Again, I'm confused by what you're getting at. Are you asking me, is the fetus going to be able to live afterwards? Or are you saying, are all the tissue, all the structures, all the cells in that fetus dead? I can tell you it does not have a heartbeat. I could be very specific with that. I could tell you that to the second it [p. 153] stopped as to what the rate is, but I can't tell you that the cells in the arms and the cells in the fingers and the cells in the brain and even the cells in the heart have died.

Q But you can tell from the ultrasound whether or not there is or is not a fetal heartbeat?

A Yes, sir.

Q Can you also tell that through a fetal heart monitor?

A I have not worked with a fetal heart monitor since 1960, and at that time, they were inaccurate even with the adult fetuses we were trying them on.

Q Would it be an accurate statement you're not familiar with fetal heart monitors at the present time?

A I don't know of any of them that would – that you could use on this type of a fetus, yes.

Q Other than ultrasound, is there any other method of determining whether or not there is a fetal heartbeat?

A If you are getting the Doppler, that is a form of ultrasound, so I think that's the same question.

Q And I'm sorry. I didn't hear what you said after the Doppler.

A The ultrasound Doppler is the audible – the ultrasound that they put on a woman's stomach to listen to the heartbeat is an adoption of the same thing we're looking at on the picture. It's just converted into an audible tone as opposed to a visual tone.

[p. 154] Q Are you talking about just digital equipment that would attach to the ultrasound?

A It's a separate piece of ultrasound equipment.

Q And do you have that equipment?

A No.

Q Now, the ultrasound, would you agree that that is a device that a person can videotape?

A It could be.

Q So you can have a record for posterity that shows what the results were of an ultrasound when it was performed?

A Yes, sir.

Q Now, the procedure that you described, the third procedure you described for doing an abortion had vacuum aspiration. Do you know, is that accurate? You do a vacuum aspiration?

A Suction D & C, vacuum, whatever.

Q That would be at the later stage after it's too late in the pregnancy to do the termination by the medication method, correct?

A No. It could be as early as three weeks.

Q Oh, okay.

Q But the vacuum aspiration, would it be an accurate statement that what you do as part of the process, you insert a tube in the uterus?

A Yes.

[p. 155] Q And the purpose of the tube is what?

A To remove the uterine contents.

Q And can you just tell us the dynamics, how that actually happens? I'm just – It's a vacuum? Is it pulling of air, or how does that actually work?

A I think the correct statement, is nature abhors a vacuum, so it's the pressure of the uterus pushing the contents through the tube to the lower pressure area.

Q Is it a power-driven device?

A Yes, it is.

Q What type of power? Electric?

A They come both battery-operated, they come hand-operated, and they come electrically-operated.

Q And when you use that method, the fetus goes from the uterus directly into the tube, correct?

A Sometimes.

Q Where else would it go?

A Very often, the tube becomes clogged, and you have to take it out, and as you take it out, the uterus will expel the contents into the vaginal cavity.

Q Is that something you intend, or is that a spontaneous event when that latter circumstance happens?

A My intent is to get it out.

Q Your intent, I would take it your intent is to, through the vacuum, remove the fetus while the tube is in the uterus?

[p. 156] A My intent in every abortion that I have ever done is to kill the fetus and terminate the pregnancy. I think that's the specific intent that I enter the room when I go to talk to the patient. That's what she's asking to do, and that's what I'm there to do, and I do what I have to do to get that done.

Q But when you're doing the vacuum method, is it your intent to remove the fetus from the uterus by delivering it partially into the vagina?

A No, I wouldn't say that. Could I ask you for clarification on that? Because it goes through the tube through the vagina. So I have to say that, yes, it's my specific intent to remove it through the vagina within the tube, but it does not always happen that way, and I enter into the procedure knowing that it's not always going to happen that way.

Q I think that was clear, or hopefully, it should be clear to the Court. At least I understand it. Now, do I understand that when you do abortions that you never attempt a procedure where you try to turn the fetus so it's in the breech position?

A I think my statement was that I don't go to the lengths that was the – There was a large amount of discussion about going in and mechanically trying to turn the fetus. I don't – I don't intentionally spend a lot of time doing that. If [p. 157] it is a transverse lie, you can't bring the fetus out sideways, so you have to bring some presenting part through, and you have to turn the fetus in order to do that. It may not be a whole 180 rotation. It may be a 90 degree rotation or a 45 or a 60, but you have to mechanically orient some portion of the fetus to come through the cervical canal.

Q But as far as deliberately trying to get the feet so that they are coming out first, do you do that?

A If it's easy to do, yes. If it's not, then I don't spend a lot of time doing it.

Q Just depends on the position the fetus is in when you start the procedure?

A Absolutely.

Q So if it's in a position the head is coming out first, you don't rotate the fetus around to get the feet, correct?

A No, sir.

Q If it's already the foot coming out first, then you take what you can get?

A That's what it is.

Q Now, as I understand your testimony, that beyond 15 weeks, you do intend to remove the fetus as intact as possible?

A I think that would be a fair way of stating it.

Q And your reasons why you want to remove the fetus intact, if possible, after the 15 weeks would be what?

[p. 158] A To minimize the maternal complications.

Q And those would be what?

A Possibilities of laceration of the cervix, perforation of the uterus, absorption of fetal cellular debris into the maternal circulation through placental, the uterine placental interface.

Q Now, what are the mechanisms that would lacerate or perforate the uterus?

A The mechanism would be a sharp-pointed object in opposition to the wall of the uterus.

Q Okay. Would a forcep create such a risk?

A It certainly could.

Q And the complication, if I understand it, and you correct me if I'm wrong, is absorption of fetal material into maternal –

A Maternal circulation.

Q By that, you mean the bloodstream?

A Yes, sir, the maternal bloodstream.

Q How does that absorption occur?

A Through the – As the placenta separates from the uterine wall, there are no blood vessels between the uterus and the placenta. There are only blood sinuses, actual cavities in the uterus. The bleeding stops because the uterus contracts and these cavities are allowed to close, and until you've emptied the uterus, the cavities remain open, so [p. 159] there is essentially a sump pump effect involved in maternal – into the maternal circulation of whatever is in the uterine cavity. It just can flow in, and the cellular structures from the brain and the cellular structures from the skin and the fetal blood are the three biggest concerning factors, and that's why we do Rh testing and why we gave Rogam to all of our patients that are Rh negataive [sic] because we know there is a mixing of fetal blood and fetal debris into the maternal circulation in every procedure.

Q Do you know what the complication rate is then?

A The frequency?

Q Yes.

A I believe the present numbers we tell the patients are less than one in a thousand.

Q And as far as your basis for that, is there some statistical support for that?

A Yes. That's numbers that come out of the CDC on approximately an every two- to three-year basis.

Q That would be the Center for Disease Control?

A Yes.

Q Now, if one was compressing the skull from the outside, do you understand what I mean from the outside, the fetus's skull?

A Okay. I think so.

Q You could do that with a forceps, for example?

[p. 160] A Yes.

Q Is it your testimony that if one compressed the skull sufficiently, one of the risks you run is having the contents of the brain or the skull be released into the mother's bloodstream?

A I'm stating that it's released into the uterine cavity. It's either going to go into the uterine cavity, or if it ruptures on the side nearest the cervix, it's going to come out of the cervix. It has been my particular experience that this happens probably equally, that it can go either way, and often goes both ways.

Q By both ways, you mean going down?

A Internal, up into the uterine cavity and out the uterus, out the os. I think that would be testi – It would

be my testimony that once this material is floating in the uterine contents, that it has the possibility of being absorbed through the sinuses.

Q Now, as far as that risk, the skull contents being released into the uterine and then getting into the mother's blood supply, is that risk at all stages of gestation or only at a certain point?

A I think probably only after the point – Well, after you've started to crush the skull where that would become a factor, or where you start to macerate the tissue of the fetus which is the 14th, 15th, 16th week and on.

[p. 161] Q Does it make any difference whether the fetus is alive or dead?

MR. HELLER: Objection. Make any difference to what?

BY MR. SMITH:

Q Does it make any difference as far as the fetal material being – the risk of that getting into the mother's blood supply? Does it make any difference whether the fetus is dead or alive?

A As far as the skin tissue, Dr. Hansen has done some studies where it is implied that this is true, the longer the fetus has been dead within the uterine cavity, the greater the chance of fetal cells sloughing, and not even with mechanical movement. Her studies were, when you had natural field demise from other than abortion standpoint, and a period of time that lasts between the field demise and the induction of labor, or the completion of the abortion, the longer you waited, the higher number

of fetal – the greater the amount of fetal elements that could be detected within the maternal blood supply.

Q Now, you described earlier in your testimony, as I understand it, a process where there would be occasions when you're trying to remove the fetus intact that you would remove to the point of the head, correct?

A Um-hm.

[p. 162] Q The answer is yes?

A Yes, sir.

Q And the reason you don't get the head out would be, there would be occasions when the cervix is not dilated far enough to allow you to remove the head, correct?

A Correct.

Q And those would be occasions in which you would attempt to reduce the size of the head in some manner, correct. Tell us the manner by which you would reduce the size of the head.

A I think the only two mechanisms possible are to use forceps to compress the skull, and rupture the skull, and allow the contents to flow out of the brain or –

Q And let me stop you there. If you did that, that runs the risk of perforation from using the forceps?

A Well, you have to use something.

Q But you would agree it does run a risk of perforating the uterus by using the forceps, true?

A There has to be a small risk of that, yes.

Q And then the other risk would be, as you said, the contents of the brain being released into the uterus and the mother's blood system, correct?

A Yes.

Q Now, the other method that you could reduce the size of the head other than forceps would be what?

A If, and you know, I mean, things don't always happen the [p. 163] way we would like to see them happen. Very frequently, we'll get down to the skull, and the skull will separate from the body cavity, I mean, from the neck. It will break off, so you have the fetus out and the head intact inside, and you're again going back and grasping the head and breaking it down, so that's a second method, I guess, and thirdly, if we can get enough of a portion of the skull outside of the cervix, we can make some kind of an opening into really any portion of the skull that has the cranial contents in it, use either vacuum aspiration, or many times we just allow the contraction of the maternal, of the uterus, the compression of the cervix and the uterus on the skull itself to empty the contents out into the vagina, and then we pull the skull on through.

Q It just comes out, correct?

A It just comes on out.

Q The obstruction really presented by the size of the head is the cervix. Once you get past the cervix –

A Once you're passed the internal os of the cervix, then you're out.

Q Now, once you've removed the fetus, you then do something to clean out the insides of the uterus?

A Once we have removed the fetus, we then have to remove the placenta normally. Sometimes, unfortunately, the placenta will come out first. That's usually, uterine [p. 164] massage, we try to do that on external massage on the abdomen of the woman causing it to separate and spontaneously pass. If that doesn't happen, then we'll go back with forceps and attempt to remove it, start it to come out, and then usually, it will come out on its own.

Q What is the curettage?

Q Curettage?

A Yeah. What is that part of the abortion? What is the purpose for that?

A Two purposes. One is to remove any remaining placental fragments off the wall of the uterus. The other reason that I do curettage on every patient is, there is a small frequency of partial moler pregnancies where you have a normal living fetus as well as a moler pregnancy tissue which is a cancerous growth. The treatment for moler pregnancy is sharp curettage of the uterine cavity. I do that. I think the incidents that's reported statistically for that happening is one in 30,000 pregnancies where you have the combined, and we have we have seen three that we have diagnosed that have had partials moles, and all three of their follow up care have been that they were already taken care of, that the curettage done at the time of the procedure was a treatment for the moler pregnancy, so I feel that that's the other reason why I do curettage on all of the women.

[p. 165] Q Is one of the purposes for the curettage to remove any of the remaining fetal debris?

A Sure, as well as placental debris.

Q Is that because the fetal debris and the placenta, placental debris, if left in, creates the risk of getting into the mother's bloodstream or infection?

A That and infection and greater bleeding. It probably will all come out and wouldn't be of any sequelae, but I think you can reduce the complications for the woman by a better clean-out procedure.

Q What is the approximate time frame that passes from the time you remove the fetus until you do the process in which you're cleaning out the inside of the uterus? Does that just – it follows immediately after?

A Minutes.

Q Okay. How long does it take to do that process of cleaning out the inside of the uterus?

A The entire –

Q By that, I mean, after the fetus is out.

A After the fetus is out, usually two to five minutes. Depends on how much difficulty you have with the placenta.

Q And if the physician does a good job, in other words, removes the remaining debris from the uterus within that five-minute period, is there, really, should there be any risk to the mother of infection or debris getting into the [p. 166] bloodstream; in other words, if you do it right, the risk should be gone?

A I think there is always the potential for bacteria to be left behind. We can't get down on that level, so the risk of infection, I can't say, is gone. I think you try to minimize it. I think that would be fair. I'm not sure you can say that it's ever gone.

Q Do you have any statistics or know any statistics on what the risk is – That essentially is getting into the skill of practitioner, so I will withdraw the question.

THE COURT: Counsel, give me a sense of how much longer you'll be.

MR. SMITH: If I could do a quick scan of my notes, I could answer.

THE COURT: Sure. I just figure I'm going to take our break, counsel.

MR. SMITH: I would guess it's going to be at least 15 minutes, could be longer. You might want to take the break.

THE COURT: Would this interfere with your cross if we break now?

MR. SMITH: No, not at all.

THE COURT: Why don't we take our mid afternoon break at this time. It's now about 2:51. We'll be in recess for 15 minutes. Doctor, you may step down.

[p. 167] (Recess from 2:51 to 3:11 p.m.; all parties present)

THE COURT: Counsel, you may proceed.

BY MR. SMITH:

Q Dr. Carhart, I wanted to ask you about your testimony where you described inducing, I have it here, fetal demise by the injection of Digoxin, is that correct?

A Digoxin or Digoxin, that's correct.

Q And that's the actual medication that would kill the fetus?

A Lanoxin and Digoxin, yes. Medication from the Digitalis group that's used in adults to control rapid heart rate.

Q And your testimony is, you do that on all patients after 20 weeks?

A All that would not have a contraindication to using the medication or that would wish not to have it done.

Q Is that after 20 weeks gestation or beginning of 20 weeks gestation?

A Yes.

Q Well, no. I mean, are you saying it's actually – it's –

A During the 20th week, I don't think, you know, I don't think I have any black and white in my practice. There is a lot of gray areas.

Q And the method you use, you do the injection, you wait 40 to 72 hours later and perform the abortion?

[p. 168] A I think I – I think I said from – I'm not sure what I said, but in reality, it would be on day one,

we would do the injection, that could be as late as, say, 2:00 or 3:00 in the afternoon. Day two, we would change lams, and day three, maybe as early as 8:00 or 9:00 in the morning or 3:00 or 4:00 or 5:00 in the afternoon, depending on how the patient had progressed, we would do the procedure.

Q And the reason why you don't do the injection prior to 20 weeks is what?

A I haven't found – First of all, I don't think there is any published data to research, so I'm stuck with my own series, I guess one has to call it, of anecdotal-type information and also in discussing with my friends, and I have not seen where the benefits of using the medication are greater than the risks in the earlier terminations.

Q If I understood correctly, when you do the injection after 20 weeks versus not [sic] your prior experiences, you didn't wait as long during your prior experiences with the injections before you would remove the fetus, is that correct?

MR. HELLER: Objection, only because I'm not sure I understand the question.

BY MR. SMITH:

Q Okay. Well, as I understood it, you testified that you used to do the injection after 16 weeks.

[p. 169] A Correct.

Q You stopped doing that, and you now do it generally after 20 weeks, correct?

A I used it 16 through whatever dating I did I stopped doing it with the 16th, 17th, 18th, 19th, and

usually the 19th, sometimes even with 19 weeks, if the patient requests it, I will do it. At 20 weeks, I would leave it pretty much up to them whether they want it or not. By 21 weeks, I really would like them to do it.

Q But during, when you used to do it between the 16 and the 20 weeks, would it be accurate that you didn't wait as long from the time you did the injection before you started removing the fetus?

A After the 20th week, the procedure goes into a third day. I wouldn't want to make a patient wait an additional day. I think, if I remember my testimony, what I said was that with only the 16- or the 12- to 24-hour time hiatus that we would have after doing the injection, I didn't see enough of a change in the size of the fetus that it was really an advantage, and I didn't see enough softening in the - softening of the fetal structures to have an advantage from it, so that I was left with possibly a little less bleeding and possibly some other benefits but also some significant, I thought, risks that would counterweigh that.

Q What's the reason for the additional third day after 20 [p. 170] weeks?

A To get additional dilatation of the cervix. You normally would remove the laminary that you have put in the first day and add more because you need considerably more dilation by the 20th week than you do by the 18th or 19th week, and also, if you have a fetus that's alive, you know, you may start at 20 weeks and two days, but you have gone another two days, and you have got a fetus that's doubling in size every two – every eight or 10

days, so the growth of a 20-week, two-day fetus is significantly smaller than a 20-week, four-day fetus, and if you terminate the pregnancy at 20 weeks, two days, then it actually starts to get smaller, so with that extra day, you know, you may be doing a pregnancy that's at least a week less in gestation by the time you are ready to do the procedure.

Q As far as when Digoxin is contraindicated, in other words, you wouldn't use it at all, is that what you mean by contraindicated?

A Whether medical problems in the patients that would preclude or make it ill advised to do that.

Q And your three reasons would be seizure disorder, heart disease and –

A Well, seizures, Lidocaine can induce seizures in people. If they have already have [sic] a seizure disorder, triggering further seizures, not that they wouldn't be treated, but it [p. 171] would be an additional risk.

Q Second reason was heart disease?

A If heart disease was being treated by Digoxin already where they might already have an maximum dose on board where any additional absorption in the maternal circulation would be a problem.

Q Is there any other medication that could be injected, then, to cause fetal demise?

A I'm sure there is, but I don't know if anyone is doing that. In very very early pregnancies, there has been some work with potassium chloride, but that's in very minute amounts. The amount needed to terminate a fetus

that size would possibly be close enough to cause severe maternal complications or even maternal death if any was gotten into the maternal circulation. I don't know of any other studies of drugs.

Q Well, when you do the injection, I assume you're using ultrasound?

A Yes, sir.

Q That's guiding you so you're injecting into the right place?

A It's giving me two dimensions of a three-dimensional world.

Q That's, frankly, it's being able to properly inject is a matter of physician skill?

[p. 172] A I believe so, yes.

Q Skills are acquired. I mean, you learn how to –

A One would hope.

Q As far as just the mother's right to choose an abortion, I take it there is some method of informed consent that you go through at the clinic?

A Yes, sir.

Q Is there a form involved, form or forms that they sign?

A We have a form, actually have multiple forms and forms that both the patient signs, forms that both myself and other people who talk to them sign, to assure that on more than just one occasion, they have asked that they consider all their alternatives, and that takes place both at

the initial counseling which is required by the State of 24 hours in advance of termination as well as, again, on the day of termination.

Q Does the form actually cover the procedure that would be used?

A If we're doing – We have a separate form if we're doing fetal termination, we have a specific form which states exactly what we are going to do, injecting the medication into the fetus or into the amniotic fluid or the placenta, and that's one consent that's signed. There is another consent for patients that are above, in the second trimester, and we have another consent for the use of the laminaria [p. 173] where we do a separate counseling, explain it to them, what the dilating, osmotic dilators are intended to do, what the complications can be, what the alternatives are, how they can avoid using them.

Q And as far as giving the mother the option on the medical procedure to be used, is that part of being informed?

A I can't state honestly whether it is or not. It's something that I discuss with every patient that's there. I'm assuming that if you say that they don't want to have an intact D & E or they do, I'm not – Maybe I don't understand your question fully.

Q You've testified so far to various medical procedures you use to perform the abortions?

A Right.

Q I'm just curious uf [sic] the form itself gives the option.

A We have different consents for each form, and I don't think we have any form that says we have 18 forms, kinds of abortions, which ones do you want and have them sign that, but depending on what they have indicated that they want, we will discuss, for instance, the medical – Everybody that signs the medical consent also has to sign a surgical consent so that we are a hundred percent certain that they understand what both procedures are and that they have chosen the medical knowing, that a given percentage, three-tenths of 1% of our current study will have to have both.

[p. 174] Q And what you've described as far as the forms, those are standard form documents that you keep at the clinic?

A Yes, sir.

Q As far as determining viability, do you yourself determine viability if the fetus is over 20 weeks? I wasn't clear when you talked about having a referral or having another physician.

A If they are coming to me where viability is a concern of mine, and I don't think 20 weeks, 20 weeks menstrual dating, that there is a remote concern, but if they are coming to me at a time when there is any concern of fetal viability, I will not use my judgment that the fetus is viable or not viable to continue with the procedure. I need the patient to come with a specific referral from her physician stating that X, Y, and Z are fetal flaws, and the fetus is not viable, and the patient needs to have this procedure.

Q And the next question is, when is viability of concern to you?

A Viability becomes a concern to me, I think, in approximately about the 22nd week. I think that, again, 22 week fetuses are not all the same. There are things that – maternal habits that can make the given possibilities of survival of the fetus at 22-week patient much less than the same identical gestational fetus in another patient.

Q I'm just trying to understand the protocol, the [p. 175] standards that you apply in making that determination. I have heard you say 22 weeks, but I'm not clear what the other factors are that you use.

A I think maternal use of drugs, maternal use of alcohol, where they are both known to cause smaller fetuses, cause increased mortality in fetuses, lack of prenatal care, fetuses that appear different than they should.

Q How do you determine –

A I think it's subjective.

Q And how do you determine the weeks of gestation?

A Generally by different measurements, calculations, by ultrasound, and comparing that with the dates that she gives us.

Q Dr. Carhart, when you had the federal investigator and state investigator contact you concerning your drug audit, was there an issue, as you understood it, as to whether or not you had a proper permit or controlled substance registration to have drugs at the location where you have them?

A I don't think they ever discussed the nature of the audit.

Q And do you have any understanding that there was some issue as to whether or not you had an active permit that allowed you to have drugs at a specific location?

A Was there an issue in my mind? Never.

[p. 176] Q Was there an issue in their mind from your perspective?

A I had my letter from the Department of Health which stated what was going on, and there seemed to be a good audit trail. I don't know why people don't talk to each other maybe, but –

Q Well, in any event, they were allowed to check your audit records for the drugs you had, and nothing has come of it since then, is that correct?

A I think the law requires I have to make that available to them.

Q But nothing has come of it since then, is that correct?

A That I'm aware of.

MR. SMITH: Nothing further.

THE COURT: Counsel?

MS. WALZ: Thank you.

CROSS-EXAMINATION

BY MS. WALZ:

Q I have just a few questions, Dr. Carhart. I think you stated previously that your clinic is located in Bellevue, is that correct?

A That's correct.

Q That's in Sarpy County, Nebraska?

A That is correct.

Q Since LB 23 became law, have you been contacted by the Sarpy County Sheriff's Department at all regarding [p. 177] investigation for partial-birth abortions?

MR. HELLER: Objection, Your Honor. I think there has been a temporary restraining order in effect.

MS. WALZ: That's correct, but there wasn't – I'm sorry.

THE COURT: Overruled. You may answer, Doctor.

THE WITNESS: I'm not aware of any contact.

BY MS. WALZ:

Q Any investigators ever call you? I mean, there was no contact at all from an investigator or any other deputy to your knowledge?

A Not with me personally. I'm not aware of it with any member of my staff.

Q Okay. What about anyone from the county attorney's office in Sarpy County, besides contact with me, between me and your counsel regarding this case.

A Well, I didn't know if that contact – We did have – The only thing that came to me was a direct communication from the district attorney's office in Sarpy – or no – the county attorney's, the deputy county attorney in his office, I had been subpoenaed as a witness for a trespassing violation by our protesters.

Q But that is not related to this case, is it, or to LB 23?

A Well, yes, it is, because they stated they called back [p. 178] and said due to the fact that we had filed suit against the county attorney in Sarpy County, that he had to –

Q A conflict of interest?

A Had to have a conflict of interest and had to appoint a special investigator.

Q But in terms of criminal prosecution instituted by our office, has that ever occurred since LB 23 was enacted?

A The only time that the bill was in effect, I was out of the state for the four days between the data the Governor signed it and the date the injunction was issued, so I don't know where –

Q I think it was eight days. I'm sorry.

A No.

Q I think it was eight days, but in any case, you never did receive a clinical complaint?

A I didn't do any patients in that interim that would come under – It was never –

MS. WALZ: Okay. That was my question. Thank you. Nothing further.

THE COURT: Counsel?

REDIRECT EXAMINATION

BY MR. HELLER:

Q Thank you, Your Honor. You were asked some questions about the risk – of, I think the risk of perforation from using forceps when you - if you were to crush the skull in an [p. 179] intact procedure, and then also about the risk of using forceps if you had to remove fetal parts that made it – smaller fetal parts that may remain. Do you recall that, those questions that were asked?

A Vaguely, yes.

Q Is the risk, in your opinion, is the risk of perforation that may occur in an intact D & E or D & X procedure greater or lesser than the risk in a D & E involving dismemberment?

A If I can go back for a second, I made – I believe I made a misstatement. I think I used the term Beier forcep and I was intending to say Sopher forcep, so if we can correct that. S-o-p-h-e-r, so if we can correct that part of it, then go on. I'm not aware of any studies that anybody that's done that said if you enter the uterus eight times with an instrument, that you have X amount of chances of perforating the uterus more than if you enter it seven times, but I think that every time – I accept the fact that every time I put anything in through the cervical os into the uterus, I'm running a chance of damaging the uterus, so the more number – the greater number of times that I

have to do that in a given procedure, I think that there is a multiplication factor of a complication rate.

Q And, then, am I right in understanding that the intact D & E procedure or the D & X procedure involves fewer insertions of forceps or other foreign objects into the [p. 180] uterus than a D & E involving dismemberment?

A Yes.

Q I wanted to call your attention to the – I guess it's Exhibit 7. Do you still have that one there?

A Yes, sir.

Q You were asked a question about the table at the top of page 10. Have you found that table?

A Yes, sir.

Q Now, that table indicates that from 1974 to 1987, the mortality rate for dilation and evacuation after 21 weeks is 11.9 per 100,000, and the mortality rate for labor induction after 21 weeks is 10.3 per 100,000, is that correct?

A That's what it states.

Q Now, if you look at the prior page, at the bottom of page nine, the last sentence, says, "Maternal mortality rates overall are higher for labor induction than D & E." Then there is a parenthetical, "But mortality rates resulting from labor induction D & E are comparable for induced abortions performed at 21 weeks or more." Then in parenthesis 11.9. Doesn't that seem to indicate that the AME believes that even after 21 weeks, that before – I'm

sorry. Before 21 weeks, mortality rates are higher for labor induction, and after 21 weeks, the rates of mortality are comparable for the two types of procedures as of – based on this table?

[p. 181] A I would have to – I think that one could draw that conclusion from this, but I have to preface that. I'm not familiar with the methods here and I don't know how much they would – we removed other complication factors. I know for induction, at least many people use anesthesia as part of the induction process, that they'll give either general or high doses of anesthetic agents during the later stages of induction, and I do know factually that CDC has stated that from 1970 through the present day, the maternal death rate from the complicating effect of anesthesia remains one-third of the total deaths that happen with abortion. That number has not changed, so if you add anesthetic component to an induction component, the compound number of deaths may certainly be higher. I don't know whether they extracted that out or not. I'm not that familiar with the study, but I think you have to take all the factors into consideration, and most of us do not use general anesthetic for dilatation and evacuation.

Q If you could just briefly turn your attention to page 11 of the same exhibit, and there is the last paragraph on that page begins, "In summary." Do you see that paragraph?

A Yes.

Q Does this appear to express the opinion of this – someone at the AMA that maternal mortality during

second trimester abortions is lower per dilation and evacuation [p. 182] procedures than for labor induction methods? Does that appear to be the opinion?

A That would appear to be what they are saying.

Q And that for procedures performed at 20 weeks gestation and beyond, the rates are similar?

A I believe that's what they are saying, yes.

Q You were asked some questions right at the beginning of your cross-examination about whether you had hospital privileges, and you mentioned a hospital called Midlands?

A Midlands Community Hospital. It's in Papillion, Nebraska.

Q Have you had hospital privileges there in the past for some period of time?

A I have had hospital privileges there since 1985.

Q Do you know what the basis is for the suspension and question about your privileges there, or is that yet to be determined?

A Well, the basis that I'm told of, as of yesterday's conversation with my attorney, was that they did not receive one letter of recommendation from one of my – one of my people, medical practitioners that I was asked to have provided, and they refused – He was told and that we received a letter that was addressed to him, but I received a copy of it stating that that was the only factor that was involved.

[p. 183] Q Do you know is there a hearing set?

A I believe it's set for June or – or July 26th or July 28th. I'm not sure.

Q Comparing, again, intact D & E with the dismemberment D & E or nonintact D & E, by removing the fetus intact, is there any difference in the risk of retained fetal parts?

A I think it's easier when you've got – I don't know a pretty way to put this – when you do a dismemberment D & E, you have a tray full of pieces, and it's impossible to take a total inventory to know that you've taken out all the tissue. When you do an intact D & E, you have either a fetus and attached placenta or a fetus and a placenta that has been divided at the cord, but either way, you have two parts, and you can see both of them, and they are intact. It's much the same as we look at a placenta in a normal delivery to make sure that it's all there. When you have one placenta and you can see a fragment missing, you can go back and look for it. When you have fragmented pieces of placenta, and the reason why the placenta is fragmented is as you are grasping part of the fetus, each time you grasp something, you can grasp a piece of the placenta as well and keep tearing off small fragments of placenta while you're doing the procedure. It's impossible to know that you have as good an emptying of the uterine cavity.

MR. HELLER: I have no other questions.

[p. 184] THE COURT: Doctor, before you step down, I have a couple of questions, and I want to concentrate now on the period of time between the 14th week and, let's say, the 20th week. During that period of time,

it is your preference to use what you call an intact D & E, is that right, the 14th week and the 20th week?

THE WITNESS: Yes, sir.

THE COURT: It's your preference?

THE WITNESS: It's my preference to try to do that.

THE COURT: Now, do you have a number for me, a sense of how many intact D & E's between the 14th and the 20th week, either as a percentage or a raw number so I'll have a sense of what we are talking about in your practice?

THE WITNESS: Are you talking about the total number of D & E's at that gestational period between 14 and 20, how many that would be?

THE COURT: Yeah, I suppose that would be the best.

THE WITNESS: I would say somewhere between five and 10% of the total number that I attempt. These are usually the 19th- and 18th- and early 20-week fetuses that come out intact, and that's a much lower percentage in, you know, quantitatively, the numbers are greater the 14-, 15-, 16-, 17-week period.

THE COURT: Than they are –

THE WITNESS: Than they are at 18, 19 and 20 weeks.

[p. 185] THE COURT: And that's because of the size of the fetus?

THE WITNESS: No I'm sorry. That's because of the patients coming in in earlier gestations. Our numbers that we start with are much greater in the lower range. We see, you know, the normal patient, the normal distribution of first trimester versus second trimester versus third or late after 24-week percentages in the United States is approximately 10% or greater than 14 weeks, and 1% of the total number are greater than 20 weeks. We see a slightly higher number than that because we do a referral base practice from North and South Dakota, Eastern Minnesota and Eastern Iowa and also parts of Kansas.

THE COURT: So between the 14th and the 20th week of the 800 or so abortions that you do a year, probably 10% of them?

THE WITNESS: Two hundred. No, probably 20% of my patients because of the skewed number probably, and this is the first year with our new reporting for the State and also with the National Abortion Federation that I will be able to tell exactly what the numbers are because we have to report that each week – I mean each quarter, but in 1996, to the best of my recollection, approximately 200 of the 800 were after the 14th week.

THE COURT: And before the 20th week?

[p. 186] THE WITNESS: Well, no, that would include those that were past the 20th week also, but that was a very small number.

THE COURT: Okay. Now, and all of those, you intend, when you begin the procedure, if you can, to do an intact D & E?

THE WITNESS: Yes, sir, I do.

THE COURT: Some of those you can purposely cause fetal demise in utero by use of an injection, is that right?

THE WITNESS: Yes, sir.

THE COURT: Tell me again, mechanically, what is the injection? What do you do, where do you inject, what medical risks are associated with the injection?

THE WITNESS: The injection process that we use is very much like the amniocentesis process used by all gynecologists or obstetricians during the determining complications during pregnancy. We use – we try to stay in the mid line where ultrasound, they are often forced to go off the mid line to avoid the fetus, and our intent, we would like to move the fetus to the mid line and go through the mid line of the abdomen because that's where least number of blood vessels are and where you are least likely to have colon or small bowel contents. We use an ultrasound in two dimensional plane to determine if the lie of the fetus, where it is, where the chest of the fetus is, and ideally, where [p. 187] the thoracic cavity and the heart is, because the closer that we can get to the thoracic cavity, the more likely the medication is to be effective early. We have injected totally into the amniotic fluid and usually see fetal death, but not for approximately 24 hours, but if you get intrafetal injection, then it's usually within 15 to 20 minutes.

THE COURT: And that's what you hope to do is to enter the thoracic cavity of the fetus as opposed to being satisfied with simply injecting into the sac?

THE WITNESS: Yes, sir.

THE COURT: Okay. Now, you don't do that procedure after the 14th week and/or from the 14th week to the 19th week, am I right?

THE WITNESS: Currently, I prefer not to. I have had some patients request it, and if they were rather thin women and 17, 18, 19 weeks, and if they – they really felt they were needed, I will do that. If there is a medical reason not to do it, then I would not do it.

THE COURT: And did I understand you to say that one of the concerns was that, for example, by using that injection, you run the risk of bowel perforation, and the offsetting benefits from doing it, such as emotional concerns of the pregnant mother, simply don't outweigh the risk of doing the procedure?

THE WITNESS: I believe that's correct. I think [p. 188] the chances of doing damage in the very early pregnancies, especially the 14, 15, 16 and 17 week because the uterus is usually down lower in the pelvis. You have to try to compress, manually compress the bowel out of the way, it becomes much, much more – It's more difficult for me to do it in the first place. You've got a much smaller target in the second place, so you are less likely to get a fetal injection than you are an amniotic injection, and I think the uterus is much smaller in its size, so you are more likely to perforate and go through the back wall of the uterus or into the back wall of the uterus and get a maternal injection.

THE COURT: All right. Now, for those situations, then, that you don't use the injection and cause fetal demise before you begin the surgical procedure, presumably – Well, am I right to presume that in the great

majority of those cases, the fetus is still alive when you begin the procedure?

A Even if I divide the cord, which I always attempt to do, when I begin the procedure, there is still –

THE COURT: I'm talking about as you begin to gown up and before you do anything.

THE WITNESS: It's always a lot, not always. Occasionally, we'll see fetal death from just the other medications that we use. I think probably once or twice in the past year, I have seen where we would have, the next morning, we would have a fetal demise, but that is very rare.

[p. 189] THE COURT: Now, can you give me a number or a percent of how many people or how many patients are we talking about who are then have a live fetus in utero that it's medically inadvisable for you to use the injection to terminate the life of the fetus, and you begin with the intention of doing an intact D & E. Can you give me a number or percentage?

THE WITNESS: I would say that in 1966 that number would have been –

THE COURT: In '96?

THE WITNESS: Excuse me, 1996, that number would have been a hundred, probably 180, 190 patients.

THE COURT: Okay. Now, you are gowned up, and my understanding is, if you can, you will – You will cut the umbilical cord at some point if you can reach it?

THE WITNESS: Yes, sir.

THE COURT: And if I understand further that that will, at some point, cause fetal demise?

THE WITNESS: Yes, sir.

THE COURT: Now, I understood you to say you don't know when fetal demise will occur even when you cut the umbilical cord?

THE WITNESS: No. I know the fetal heart will stop in probably 6 to 10 minutes, 90% would stop, but I think, you know, if you were to check at the cellular level, there is [p. 190] still fetal life there.

THE COURT: And typically, when you cut the umbilical cord, would you wait the six to 10 minutes?

THE WITNESS: No, sir, because as soon as you do anything to the uterine contents, we've already been giving drugs that cause uterine contractibility. Then once you rupture the membranes and go in and start, then every delay of even a minute, you still have some oozing of blood, some bleeding even not from the maternal circulation through the placenta, there is still some active transfer of blood there, so you're losing maternal blood just by waiting, even if you divide the cord, as well as fetal blood. I don't think there could be proposed an advantage to waiting.

THE COURT: At least an advantage for the maternal mother?

THE WITNESS: For the maternal mother.

THE COURT: Sometimes you can't cut the umbilical cord because you physically can't reach it?

THE WITNESS: Sometimes, exactly. You can't reach it, more frequently, because as soon as you rupture the membranes, part of the fetus spontaneously presents through the cervical os, either an extremity or the skull, and then you can't get around it to get to the cord, or you could, but you're running the risk of perforation and manipulation that is not really ethic indicated.

[p. 191] THE COURT: In those situations in which you either cut the umbilical cord, or you can't cut the umbilical cord, if the fetus presents in a way that is easier for you to extract the fetus whole but for the head, you will do that, is that right?

THE WITNESS: Yes, sir.

THE COURT: And you do that manually with forceps and your finger at some point, is that correct?

THE WITNESS: That's correct.

THE COURT: Of those 180 that we talked about, what percentage, or if you can suggest one of that number, are presented feet first up to the head, so-to-speak? Can you give me a sense? Is it half of them, a third of them, more than that?

THE WITNESS: The ones that come out intact, I'm saying we are talking probably 10% of 200, say, 20 of them. That's already eliminated the transfer of slides, because I would have taken them down from being intact, probably 50-50. I think it would be an even split whether the skull is first or the feet are first.

THE COURT: So in raw numbers, that's how many.

THE WITNESS: Probably 10.

THE COURT: And what I just described is what you would prefer to do if you could, if the fetus presented itself in a position within the uterus, you would prefer to [p. 192] do that because in your opinion, that's the safest way of aborting a fetus using that D & E procedure.

THE WITNESS: If you have the adequate dilation and you have the fetus present feet first or skull first, and just this last Saturday, we had an exact 19-week patient with a skull impacted in that we were able to just use a tenaculum and make a small laceration in the skull. It spontaneously expelled the cerebral contents, and the fetus passed instantly out of the vagina.

THE COURT: And when you did that, was the body of the fetus saved for the skull in the vaginal cavity?

THE WITNESS: No. That was the opposite. That one was skull first, and the only thing we opened was the portion of the skull that was outside. There was a portion of the skull outside of the vaginal cavity, and we made an in session [sic] in that and extracted the cerebral contents, and the rest came out.

THE COURT: But if you had your druthers, if you could design a presentation, it would be, am I right to say, that it would be that you would have the fetus presented through – well, presented feet first?

THE WITNESS: I think the feet-first presentation you can do with the least amount of dilatation because of the way that you can pull the shoulder down one at a time and get the arms out one at a time instead of

two, then get to the [p. 193] base of the skull with less dilatation than you can. I think that's the absolute safest scenario.

THE COURT: And that's what you would hope to do as you begin the procedure?

THE WITNESS: Yes, sir.

THE COURT: Counsel asked you about your experience, and I want to ask you a couple of questions in that regard too. My understanding is you were with the Air Force, is that right?

THE WITNESS: After my graduation from undergraduate school, I went on active duty as the medical administrative officer in the Air Force. I remained on continuous active duty for 21 years. During that time, I went – I was selected through candidate program and went to medical school while in the Air Force and then did my internship and residency while in the Air Force, and my final assignment was at Offutt Air Force Base from 1978 to 1985 as chief of surgery there. Well, I didn't come as chief of surgery, but I ended up as the chairman of the department.

THE COURT: As chief of surgery, what does that mean?

THE WITNESS: Well, I was, when I arrived, I was a general surgeon, okay. Then I was promoted to the chief of the department, being I was over the other general surgeons that were there, and then I was finally promoted to chairman [p. 194] of the department of surgery which was OB-GYN, orthopaedics, general surgery, and the emergency department came under that too.

THE COURT: How many physicians did you supervise?

THE WITNESS: Twenty-five probably, 20.

THE COURT: Now, when you were with the Air Force, I take it you learned how to do abortions in the Air Force?

THE WITNESS: That's true. I was in a civilian hospital on rotation. I didn't actually do any while I was on – I was on active duty when I did them, but I was not in an Air Force environment.

THE COURT: All right. When you were in active duty, were you permitted to do abortions in Air Force hospitals?

THE WITNESS: No, sir.

THE COURT: All right. I believe that's all the questions the Court has. Counsel, any follow up?

MR. HELLER: Just one or two, I believe, in connection with the Court's questions.

THE COURT: Go ahead.

REDIRECT EXAMINATION

BY MR. HELLER:

Q First, you indicated that you intend, in the category of procedures, between about 14 and 19 weeks, to start out hoping that you are going to be able to do the safest [p. 195] procedure which involves feet-first presentation and intact removal, but that that doesn't always

happen. In fact, that may only happen in about – in less than 20 cases.

A Ten percent in '96.

Q Instead, when you don't get that ideal result, is it correct to say that you end up removing portions of the fetus instead of removing it intact?

A Yes, sir.

Q Do you remove the portions of the intact fetus while the fetus is still alive?

A Yes, sir.

MR. HELLER: Nothing else, Your Honor.

THE COURT: Counsel?

MR. SMITH: Nothing else.

THE COURT: Counsel?

MS. WALZ: Nothing.

THE COURT: Thank you, Doctor you may step down. Counsel, you may call your next witness.

MR. HELLER: Thank you, Your Honor. Plaintiff calls Dr. Jane Hodgson.

DR. JANE HODGSON, PLAINTIFF'S WITNESS, SWORN

THE COURT: Counsel, you may proceed.

DIRECT EXAMINATION

BY MR. HELLER:

Q Thank you, Your Honor. Would you please state your [p. 196] name?

A Jane E. Hodgson.

Q Before I begin my questions, I just wanted to give you some of the documents that I may be referring to.

A I'm afraid I'm going to have to ask you to speak a little louder.

Q Okay. The exhibits I'm giving you are Exhibit 7 and Exhibit 14 and Exhibit 19 and a copy – This isn't an exhibit but it's a copy of the Nebraska law at issue in this case.

A Um-hm.

Q I will try to speak into the – more clearly into the microphone. Is that better? Can you hear me better?

A That's much better. Should I use it too?

Q That will be fine, I think. Can you tell me, what is your profession?

A I'm a physician, obstetrician, gynecologist.

Q Are you board certified in any specialty?

A In obstetrics and gynecology.

Q When were you board certified in obstetrics and gynecology?

A I was certified in 1949.

Q Are you a member of the American College of Obstetricians and Gynecologists?

A Founding Fellow.

Q One of the exhibits I gave you, Exhibit, I believe it's [p. 197] – Which one is your CV? Do you have your –

THE COURT: Exhibit 14, counsel.

THE WITNESS: Number 14.

BY MR. HELLER:

Q Can you identify Exhibit 14?

A It's my curriculum vitae.

Q And is it, to the best of your knowledge, accurate?

A I beg your pardon?

Q Is it accurate?

A I believe so. Yes.

Q Have you published any articles on abortion?

A Quite a number. I haven't counted but probably 50 to a hundred are on that subject.

Q Have you – How many abortions have you performed?

A Well, I have performed or supervised at least 30,000 as director of a number of clinics throughout the country since *Roe v. Wade*.

Q Have you also delivered babies in your practice?

A Yes, prior to – in the pre-*Roe* period and subsequently to, I have delivered at least 5,000 babies.

Q Did you perform any abortions prior to 1973 when the Supreme Court issued the *Roe v. Wade* opinion?

A I performed an abortion in 1970 for the purpose of challenging Minnesota's abortion law, performing an abortion on a patient that was 12 weeks pregnant and had been [p. 198] diagnosed with as having had Rubella during the first month of her pregnancy.

Q I will return to that in a moment. Prior to the abortion you performed in 1970 –

A Right.

Q – had you performed abortions before that in your career?

A Well, only in very unusual situations with consultation with our abortion committees at the hospital, cases of women that where it was necessary to save a life or in cancer patients or something of that nature.

Q And were those abortions performed in Minnesota?

A Yes.

Q Where are you currently licensed to practice medicine?

A I'm sorry?

Q Where are you currently licensed to practice medicine?

A I'm currently licensed in Minnesota and in the District of Columbia, and that's it for now.

Q In 1970 when you performed the abortion for the woman who had had Rubella, what was the result of your performing that abortion?

A Well, I sought help. I went to the federal court prior to performing the procedure asking them for an injunction to prevent my being prosecuted under the law. I was so frustrated with the hypocrisy around the whole abortion [p. 199] situation, the fact that there was two levels of patients and no equal justice for all and the need for abortion services for women. I had been practicing under that since 1947, and I saw the beginning to feel the necessity for a legalizing abortion in the United States. I had spent a lot of time overseas in Third World countries where abortion was illegal, and I saw the problems that were common to countries that did not have legalized abortion, and so I – The federal court failed to give me any response, and time was passing, and I didn't want to – In those days we were afraid to do abortions over 12 weeks, and so I went ahead and openly performed it with consultation from a number of my colleagues, and then I was indicted and prosecuted and convicted, and I did not have that conviction overturned until, oh, two weeks after *Roe v. Wade* when the Minnesota Supreme Court had heard my appeal, but they did not hand down any decision for all that time.

Q What, prior to 1970 when you did occasional abortions when a woman's life was in danger, what method was the prevalent method in the United States for abortions?

A Well, every specialist in the field did just the ordinary D & C procedure which we called the sharp

curettage. We didn't have any suction equipment. It was not even discussed in the United States. It was popularized in Europe, in Eastern Europe mainly, and in England, and it was [p. 200] first published in our American literature, we saw articles concerning suction in 1967, and I became aware of it at that time, but there was no equipment available. You couldn't – It wasn't made in the United States. It had to be imported from London.

Q After 1970 and the abortion for which you were convicted, did you continue to perform abortions at what point after that? Did you continue to perform abortions?

A Well, no. Well, I could not perform them in Minnesota. I was on probation, and – but I was offered the job of director at a preterm clinic in the District of Columbia. They had recently opened one of the largest abortion clinics on the East Coast, and I went out there and took over the directorship and indirectly learned very quickly how to do suction abortion, and we were doing about a hundred a day there, and I remained there until a year following *Roe v. Wade*. We did a great deal of research on complications and on technique, and we were able to disprove some of the fallacies in regard to abortion, the dangers of abortion. We had had it so drilled into us all through the years that it was a very deathly thing to do, and that just invading the pregnant uterus was extremely risky. So we had an ambulance down in the basement, and we were all prepared for all these complications, but they never occurred, and we kept very careful records, and we published our results, and within a [p. 201] couple of years, we established the safety of the abortion procedure.

Q At that time, you were using the suction method of abortion?

A Using the suction, yes. We had to import the equipment from Rocket of London.

Q During your time at the preterm clinic in Washington, up to what stage of pregnancy did you perform abortions?

A We theoretically were cut off at 12 weeks, but we didn't have an ultrasound in those days, and so our sometimes our estimates of gestational age was definitely off, and we would find doctors would get involved in procedures that were further along. The pregnancy might be 14, 15, 16 weeks, and so we were almost forced to go a little bit higher just from human error.

Q What procedure – Did you use a different procedure for 14 or 15 week pregnancies, or did you also use suction?

A Well, we just had the suction then, and that was all we did. We could do modified types of D & C's, but we would try things, we were, for quite for a time, it was popular to get larger cannulas up to size 16 which would be the size appropriate for a 16-week pregnancy, and but these large cannulas were no improvement because they were dangerous. You have to go into the uterus with the cannulas, and obviously, a big, a larger size cannula was more of a danger [p. 202] as far as uterine perforation, so I think on the whole, it has been abandoned throughout the country. They rarely use the larger size. They go right into the D & C procedure.

Q What would a woman, back at that time, let's say, between 1972 and 1974 who needed an abortion later than 14 or 15 weeks, what procedures were available to women at that time?

A Well, they really had to wait until they – they were out in general. They were told that they would have to wait, and then at 18 weeks, they might, in some states, would get an induction where it was legal, but, of course, in many states it wasn't legal. Abortion was still illegal.

Q Well, until what point they would have to wait, to what point to get an induction?

A Induction.

Q How late, how far along pregnancy?

A They would have to be far have a large enough amniotic sac so that it's easy to get into it and withdraw amniotic fluid, and that is usually not before 16 weeks.

Q What method of induction was used in the early 1970's? What type of induction was used?

A They were mainly salines.

Q And are saline abortions, saline inductions, still used in the United States?

A Saline is almost, I think it's obsolete in many places [p. 203] considered so, because of the danger. It's quite dangerous and has to be very carefully used in order to prevent reaction.

Q Where are we getting that from? Oh, there it is. After 1974, where did you work next?

A I returned to my home in St. Paul and took over as director of the Fertility Control Clinic which I actually established at St. Paul Ramsey Medical Center which is a teaching hospital connected with the University of Minnesota, and there I became interested in the more advances [sic] terminations and concentrated on induction procedures, also directed the clinic at which first trimester abortions were performed, and we provided sterilizations and did operations, ectopics and all the related type of problems.

Q What type of induction procedures did you use there?

A We used we concentrated on extra amniotic Prostaglandin F2 Alpha. It's a system that promoted by Dr. Bigdeman from Sweden and a technique in which the Prostaglandin is very carefully instilled through a Foley catheter in the cervix, and as the solution enters the extraamniotic, extraamniotic cavity, the cavity around the – between the uterine wall and the amniotic sack, so it was administered at a very slow rate and very well controlled by a Harvard pump which would very carefully control the rate at which the drug was administered in the patient, and if any of these complications were [p. 204] reported now, the high blood pressure and the idiosyncrasies that some patients will have to the drug, we could stop it instantly, and I am really amazed that they even talk about using it intramuscularly because I know that is dangerous, and I'm surprised that they don't use this other technique.

Q Did you use any other techniques at Ramsey, St. Paul Ramsey for doing second trimester abortions?

A Well, the same time we were doing D's & E's, D & E's by the usual method, the standard method, and we were doing those up till probably – we didn't encourage them over 18 to 20 weeks because it's always felt there was a great deal of intrauterine manipulation with sharp instruments, and they were hazardous, particularly in a training program where you were trying to train residents and interns, so induction was really safer for that type – for training purposes.

Q After the period you worked at the St. Paul Ramsey Hospital, where did you work next after that?

A We spent a year with Project Hope in Egypt at the university there.

Q After you returned from Egypt, where did you work?

A Then I spent some time in San Francisco at the University of California at San Francisco in their – I took over the Fertility Control Clinic there, and interestingly, in California, the attitude – the policy then was no inductions at all. They did D & E's up to 25 weeks.

[p. 205] Q And did you also do D & E's up to 25 weeks?

A Oh, yes, yes. I was in charge of that program. I took temporarily while the director was on – what do you call it – leave.

Q Who was that person who took leave?

A Dr. Darney, Phillip Darney. He took a sabbatical.

Q Do you have an opinion about whether currently, an induction procedure, say, at 18 weeks, is more or less safe than a D & E procedure at that point in gestation?

A Would you repeat that?

Q I wanted to get you to compare the safety –

A Um-hm.

Q – of a D & E and an induction at 18 weeks pregnancy. Do you believe they are equivalently safe, or is one safer than the other?

A Well, the figures, of course, have always cited the higher complication rate for the induction, but I think you've got to specify what – which medication you're using in your technique and the technique. Probably, I personally would feel that, well, again, I would have to see the patient to really –

Q What are the – Are there advantages, aside from the safety issue, are there advantages or disadvantages for a D & E?

A From the patient.

[p. 206] Q Yeah.

A That's what I meant. Some women will tolerate the induction procedure very readily because, particularly if they have had a number of pregnancies and gone through labor and they know what to expect, whereas women who have never had a child, the young teen-ager isn't going to do well with an induction where they are forced to be inactive, and it's the uncertainty of it, and all they would much rather, I think, go through the D & E.

Then you must take into consideration the condition of the cervix, the patient's general health and the rest of it, so I couldn't just off the cuff say one is better than the other. I think you have to adjust it to the patient and your setting, and the hospital setting, and the hospital care is terribly important in the induction, the kind of nursing care that you have.

Q Can you describe for me, in general, what a physician like yourself would do in terminating a pregnancy by dilation and evacuation, by D & E? What does that involve?

A Well, first of all, the most important thing is the dilatation and the cervix, and that it be adequate, and that is – We first started laminaria back in '72 in Washington, and gradually the use of laminaria spread, and it has been extended over a three-day period. I think Dr. Herron promoted that. He would often insert it three days in a row, and they would come in 24 hours, and then return the next [p. 207] morning and the laminaria would be removed and replaced with additional laminaria, and that would be done for three different times, so that there was a total of 36 hours, and then come in, then the procedure would be performed. By that time, dilatation would be achieved anywhere from two to three, four inches even in diameter, and – the cervical opening, and then the operator will – may or may not use the cervical block. Usually not if the dilatation is adequate and varying types of sedation. In San Francisco, we always gave patients intravenous Fentanyl which didn't really put them to sleep, but it gave them very good temporary pain relief, and the membranes are ruptured, and the – and then with especially the suction is applied to remove all the amniotic

fluid and what you can with the cannula, but obviously, then, you are left with the fetus to remove, and this was done ordinarily piecemeal by dejoin – The fetus is removed, and some of it, if the uterus is contracting, why, it will voluntarily, there will be expulsion of fetal parts down into the cervical canal, and it will be easy to grasp them and remove them, but some people will start using Pitocin at that time just to aid in the performance.

Q When you talked about ordinarily, you would remove parts, you began removing the fetus.

A That's right.

Q And what sort of instrument do you use to remove parts [p. 208] of the fetus?

A We always favored the Sopher forceps. They are very light weight and were designed by Dr. Sopher of London just for this purpose, or many, there are a number of other forceps that are good, and some people just use plain ovum forceps, but they aren't bent properly. They are not strong enough really.

Q When you begin the D & E, is the fetus alive?

A Well, that may be. I mean, it can be or it may not be. After the three-day laminaria procedure, many women will rupture membranes themselves, or may go into early labor, and there will be no fetal heart, but during this procedure, we are not constantly checking fetal heart because it has been understood that the demise of the fetus will take place, and I think it's very hard often on the woman patient to keep emphasizing the fetal heartbeat, and so in a situation like that, we just don't check it, so I don't know. I might not – I wouldn't

normally deal with the time when and if the fetus expired. It would depend on the age, of course, of the fetus too. It wouldn't matter if it was up – if it was below viability. If it was over viability, that's a different point.

Q Well, let's take the example of previability or restrict our discussion to previability. If you were looking at the fetus through ultrasound just before you started the [p. 209] procedure, would you be able to tell if it was still alive?

A Well, it would depend on your equipment. We didn't have equipment during procedures until relatively recently. Now, of course, they are common in every clinic, and almost everyone is doing any number of procedures, has ultrasound available some use them routinely. Other doctors don't, as far as determining whether they are alive or not. That, too, is not absolute.

Q Well, if you, could you see through ultrasound whether the fetus had a heartbeat?

A Probably if the patient wasn't too obese.

Q In doing the D & E that you're talking about, what's typically, what typically actually is done with the forceps? Can you describe how the forceps are used?

A The forceps, you grasp the fetal parts, and you often don't know what they are, and you try to pull it down, and it's – It's very crude. It's simply all there is to it.

Q Well, can you describe in more detail if you were doing a D & E without ultrasound?

A Um-hm.

Q How would you know what you were grasping with the forceps?

A You don't sometimes. Maybe you could tell with the index finger of the other hand, or you could feel it, try to determine the position, and you try to bring it down, you try [p. 210] to bring down an extremity, but you are not always able to do that.

Q And –

A You may want to dilate further if you are unable to be successful in getting a part down.

Q In getting a part down, does the part actually, does the fetus come, break into pieces, or does it remain in one piece during the D & E; in other words, are you removing it piece-by-piece or in one piece?

A You have to remove it piece-by-piece.

Q What's the typical size of a piece that would be removed?

A Oh, they vary so much.

Q Just some examples of what might be removed?

A Well, the four extremities and parts of the skeleton of the spinal column, in the cranium, of course, is the largest part, and that is always at the back of your mind that you – about getting the cranium because that's the largest diameter to pass through, and you may have to reapply the forceps and actually capsize the head in order to get it through the cervix.

Q At what point during that procedure that you're describing, assuming the fetus starts out living with a heartbeat, at what point does the fetus undergo demise?

A Well, that's anybody's guess. Probably as soon as you [p. 211] have it, probably some bleeding takes place when you remove the extremities, or you may cut – The cord can be cut and it can exsanguinate. There are a number of ways.

Q Could you be removing an extremity, let's say a foot?

A Um-hm.

Q And the fetus could still have a heartbeat?

A That's right.

Q Have you ever done a procedure, a D & E procedure where you removed the fetus intact, in one piece?

A Yes, that does happen sometimes without planning it that way, without any intent, and, of course, it's kind of a victory. It's always much, much shorter, and, you know, you don't worry about having left parts behind, and that will happen where you have adequate dilatation and a contracting uterus. It's very helpful.

Q You mentioned first, you mentioned that parts won't be left behind.

A Um-hm.

Q If you have it out intact. What's the danger of parts being left behind?

A Well, that can be horrible complication. The patients can get infected or bony splinters can come – can

cut the uterine wall and perforations are common, uterine perforations are fairly common in this procedure, and that is one reason that I think I've always been conservative about [p. 212] doing them beyond the 18th to 20th week.

Q Well –

A I think that the induction can be made as safe.

Q If you were to remove the fetus intact, in one piece, would that require more or less insertion of instruments?

A It would be much less, and the less instrument manipulation, of course, the higher your safety.

Q Do you have an opinion, then, about the relative safety of an intact D & E versus a nonintact?

A Yeah.

Q What is your opinion?

A Well, I think it's, hopefully, I haven't personally done any with intent, so I don't know how hard, difficult it would be, but from what I read about it and what I have seen, I think that it's probably an advance in technology and may well prove to be an improvement over what we have to – over what we have been working with up to now, and so I have been very interested in Dr. Haskell's work ever since he first published in '92, I think it was, his article, and the few that have followed his technique and are reporting on it, the reports are quite favorable. I personally have had no contact with that myself.

* * *

[p. 213] THE WITNESS: Yes, I have seen this before. This is the AMA report on intact D & X, is it not?

BY MR. HELLER:

Q Well, it's a portion of it.

A Yes, I recognize it.

Q It's a portion of it. If you would look at the last paragraph on that page?

A Yes.

Q Could you read that paragraph to yourself and just tell me whether you agree with it?

A I do very much.

[p. 214] Q Do you know, Dr. Hodgson, do you know if the – So you agree with that last paragraph?

A Yes.

Q Do you know if the American College of Obstetricians and Gynecologists has taken a position on intact D & E abortions?

A Yes. They realize – they have stated that they felt that there were some unique situations in which it was indicated, and –

* * *

[p. 215] Q If you turn to the second page of that document, does it express a conclusion about intact dilatation and evacuation? Does it reach any conclusion?

A Yes. It points out, it's one of the methods available in the situation where you're terminating a pregnancy to save the life or preserve the health of the mother. I assume this is a case of a viable fetus.

Q Well, I'm not sure if it is. What I want to see, is there anything in there that indicates whether the procedure, this type of procedure is considered safe, if you want to take a moment to look it over. Well, actually –

A It points out that the intact D & X is one of the methods available in performing D & E's, and it could – it may be the best or the most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor in consultation with a patient, based upon the woman's particular circumstances, can make this decision.

Q Dr. Hodgson, do you agree with that statement by the [p. 216] American College of Obstetricians and Gynecologists?

A I do.

Q If you would now turn to the Nebraska law which I gave you a copy of, I hope. Do you have a copy of that?

A I do.

Q Could you turn to page four of that document? On that page, there is a definition of partial-birth abortion. First, I want to ask you, is partial-birth abortion a medical term?

A No.

Q Is it a term that you have ever seen in any gynecological textbook or articles?

A No, I never have.

Q Looking at this definition, and if you want to take a –

Why don't you take a moment to read it through?

A I have read it many times.

Q All right. If the types of procedures described here were illegal, what – Well, let me ask you, what types of procedures do you think this definition might cover?

A About 95% sent [sic] of abortion procedures, I think, really, if you applied – if you applied it to them.

Q For example, in a –

A Well, in a first trimester, you are frequently – you are drawing fetal parts even if the cord – even in more advancement, if the cord prolapses, you have got part of the [p. 217] fetus in the vagina when the fetus is still alive, and in the early trimester, you've got the fetus, the embryo going through the suction cannula and into the vagina, and we don't know when, of course, that embryo is no longer living, but we wouldn't be able to determine that very well, but it takes place, and so and as you go further along the stage of gestation, why, the same thing can apply at anytime during an abortion procedure. The cord or part of the fetus can come, enter the vagina spontaneously. You would have no control over it.

Q One of the discussions in this case has been about the level of intent required to violate this law. How many

abortion methods does the physician have the intent of taking a portion or the entire fetus through the vagina while it's still alive?

A Well, all of them. They have the intent to – It is understood, all forms of abortion, that there is going to be fetal demise, and when it happens is extremely variable, and so I fail to understand the purpose of the partial-birth abortion law because why they insist that it be done when the fetus is still alive, why that makes it any different or more or less ethical.

Q Is it – Is this a procedure that could be done when a fetus is dead?

A Well, then the law apparently doesn't apply. I mean, [p. 218] the partial-birth abortion ban would not apply to a dead fetus.

Q Are there situations where –

A But how does that make it any different? I don't understand why a person, a doctor would be exonerated if he produced that, killed that fetus before and – or after.

Q Well, would there be any different risk to the woman if this procedure or the partial-birth procedure were done with a live versus a dead fetus? Is there any difference to the woman's health?

A Not that I know of. I mean, not on the face of it, no, not unless there is some details that I don't know about.

Q You talked a little bit about the first trimester abortion.

A Um-hm.

Q And its coverage under the law. In the D & E abortion, not the intact one but the standard one or the traditional one, is it the doctor's intention to remove a portion of the fetus before killing it?

A I don't think the doctor – If this is a previability case, I don't think that the doctor is even thinking about it because it's inestimable. The demise is inestimable, and this is just the job to be done.

Q Well, what I'm trying to ask is, when the doctor sets out to do the D & E, say, at 15 or 16 weeks?

[p. 219] A Um-hm.

Q The doctor intends to take what is a live fetus and end up with a dead fetus?

A Right.

Q And in going from one point to the other, the doctor intends to remove portions of the fetus through the cervix?

A Right.

Q And if the doctor, for example, removes a foot first, the fetus may well be alive?

A Right.

Q If, on the other hand, the doctor removes the head first, then the fetus is not likely to be alive, isn't that right?

A It would depend on if it was a very easy delivery if he performed with forceps, why, the fetus might still be alive.

Q What do you consider to be a living fetus? Do you consider that to be having a heartbeat or living tissue? What is your – What would be your way of defining that?

A Well, that certainly is a debate. I think the heartbeat is probably the best that we can – indication we would have, but it probably tapers off very slowly, or it can be a very common goal sort of thing, too, because I would think that during long labors, when we know by the monitors on the infant, that the death can be quite slow and dragged out. We can tell by the fetal monitors that it's very protracted, but [p. 220] the same thing may happen with the D & C, but it's a quick procedure and certainly they exsanguinate or they suffocate or whatever, something happens, and they expire.

MR. HELLER: I have no further questions, Your Honor.

THE COURT: Counsel, what are the doctor's travel plans?

MR. HELLER: The doctor will be available in the morning if the Court would prefer to continue in the morning.

THE COURT: Mr. Smith, what would you prefer?

MR. SMITH: I think I'm going to be pretty brief, 10 minutes, I hope.

THE COURT: That's fine. Would you like to go now?

MR. SMITH: I would just as soon go now.

THE COURT: Do you have a sense –

MS. WALZ: I don't anticipate having any questions at all.

THE COURT: Why don't you inquire then, counsel?

CROSS-EXAMINATION

BY MR. SMITH:

Q Dr. Hodgson, can you hear me okay?

A Not too well. I'm sorry.

Q If you can't hear me, you'll let me know, won't you?

A Yeah, I will try.

Q When did you last perform an abortion yourself?

[p. 221] A About one year ago. I have had spinal surgery since that time twice, and I have had to forego any actual surgical procedures.

Q And were you actively performing abortions up to that point in time?

A I was, um-hm.

Q Now, just to understand these different medical organizations, Mr. Heller showed you this statement of policy from the ACOG?

A Yes.

Q And is that a different organization than the American Board of Obstetrics and Gynecology?

A Yes, it is.

Q And is the American Board of Obstetrics and Gynecology, is that the board that certifies physicians in that specialty?

A That's right.

Q And a person who belongs to the American Board of Obstetrics and Gynecology has to go through some process to be certified as a specialist?

A Oh, yes.

Q The American College of Obstetricians and Gynecologists, do they actually, is there a certifying process where one –

A No.

Q Now, as far as – You're familiar with the Center for [p. 222] Reproductive Law and Policy in New York?

A Yes.

Q Are you affiliated with that organization?

A Am I what?

Q Affiliated. Are you on the board of directors?

A I'm on the board of directors. I have been for about a year.

Q And the Nebraska law on partial-birth abortion, is that similar to the proposed federal law on partial-birth abortion, if you know?

A Very similar.

Q At least as far as the definition of a partial-birth abortion?

A Right. It does not include, I don't think, the amendments that the AMA put on it.

Q And as far as the federal partial-birth abortion law, have you been active in any manner in opposing the enactment of that legislation?

A Just not specifically, no. I mean, I belong to a lot of organizations that are opposed to it, but I haven't done anything specific.

Q Okay. Are you familiar that your picture appeared in an advertisement for the *New York Times* this year in connection with the Center for Reproductive Law and Policy, essentially saying why the proposed federal legislation would be bad [p. 223] medicine?

A Yes, I'm aware, and that was primarily in protest of the AMA restriction of their support for and the fact that the AMA supported a law which would criminalize the surgical procedure regardless of what it was. It wasn't particularly, as far as I'm concerned, the partial-birth abortion act, but was the fact that they would criminalize the surgical procedure by people, individuals in Congress who were totally uninformed about what they were doing, and it was something I felt very deeply about.

Q Would it be an accurate statement that the AMA has gone on record, then, as supporting the proposed federal legislation banning partial abortion?

A I'm sorry?

Q Would it be an accurate statement that the American Medical Association is on record as supporting the federal legislation banning partial-birth abortion?

A Supporting it, you said?

Q Yes.

A Yes, to my dismay, that's true.

Q And you –

THE COURT: Just a minute. Just a minute, counsel. Is there going to be any proof of that, counsel, aside from this witness's understanding of her belief?

MR. SMITH: Well, that's a good question, Your [p. 224] Honor.

THE COURT: The reason that I ask, I'm willing to allow hearsay statements that explain an expert's beliefs, to understand the expert's belief. I'm not willing to allow an expert to give hearsay testimony to prove the truth of the matter asserted.

MR. SMITH: Okay.

THE COURT: If you are offering this testimony to prove the truth of the matter asserted, just as counsel's trying to get in the back door Exhibit 19 or whatever this thing is, I'm not receiving it to prove the truth of the matter asserted, only that this witness thinks that this is part of the reason for her opinion.

MR. SMITH: I would offer it for the purpose of showing what the witness's personal views and beliefs are. Whether or not that, in fact, is the case of the AMA, I

won't offer it for that point, but to at least explain her personal views and beliefs and what she advocates.

THE COURT: Thank you. With that understanding, that helps me. Thank you.

MR. SMITH: Nothing further, Judge.

THE COURT: Counsel?

MS. WALZ: I have no questions.

THE COURT: Counsel?

* * *

[p. 232] THE COURT: Good morning. We're on the record again, continuation of our preliminary injunction hearing in Carhart versus Stenberg. Is counsel for the defendants – Are counsel for the defendants ready to go?

MR. SMITH: Yes, Your Honor.

THE COURT: You may proceed.

MR. SMITH: We would call Dr. Christopher Riegel.

DR. CHRISTOPHER RIEGEL,
DEFENSE WITNESS, SWORN

THE COURT: You may proceed.

DIRECT EXAMINATION

BY MR. SMITH:

Q Would you state your name?

A Christopher Joseph Riegel.

Q And what do you do for a living?

A I'm an obstetrician and gynecologist and infertility specialist in Dallas, Texas.

Q And as far as just giving your background history, could you give us background on your college education; in other words, where you went to school, when you graduated, what degrees you obtained?

A I went to Southern Methodist University where I got a chemistry degree with honors in 1983 and also a sociology degree. They were both BA's. I went to medical school at the University of Texas Hall Science Center in San Antonio from ['83] to '87 where I got my medical degree. I did a [p. 233] one-year internship in pediatrics at Children's Medical Center in Dallas from '87 to '88, and then from '88 to '92 did a four-year residency, internship and residency in Obstetrics and Gynecology at the Parkland Hospital in Dallas at the University of Texas, Southwestern Medical School. In '92, I went into private practice in Dallas.

Q Now, the residency program that you completed at the Parkland Hospital, do you know whether or not that residency program has any national reputation?

A It's considered one of the top two or three OB-GYN programs in the country.

Q And you went into private practice in 1992, you say, in Dallas?

A Yes.

Q And have you practiced medicine continuously since 1992 in Dallas?

A Yes.

Q And do you practice in any specialty area?

A My practice is probably about 60% obstetrics, 30% gynecology, and about 10% infertility at this point.

Q And are you certified by any recognized specialty boards?

A Yes, I'm a Diplomate of the American Board of OB-GYN.

Q How do you become a Diplomate in the American Board of OB-GYN?

[p. 234] A At the end of your residency, you take a written examination. When you pass that, you take – When you have been in private practice a couple or three years, you take an oral examination, and you become certified if you pass the oral examination.

Q And when did you become board certified?

A I took the examination in November of '95.

Q And became certified then?

A Right thereafter, within a few days of that.

Q Do you have hospital privileges in any hospitals?

A I have active staff privileges at Columbia Medical Center of Plano in Plano, Texas, Presbyterian Hospital of Plano in Plano, Texas, and I have courtesy privileges at Trinity Medical Center in Carrollton which is an adjoining. Those are all suburbs of Dallas.

Q What's the difference between hospital privileges and courtesy privileges?

A Full active staff privileges basically means that you do quite a bit of work at that facility, necessitating active privileges, where you attend meetings both for your department and for the entire hospital staff, and you take call responsibilities in the emergency rooms and in labor and delivery, versus courtesy privileges is where that you can do procedures at the hospital. However, your role at that particular hospital is limited, and just because you don't do [p. 235] very many procedures there, you don't need to be on call for the ER and go to all the meetings. It's kind of a status where it's not as restrictive on your time, basically, but you still have basically full privileges. You are just not there very much.

Q And in your practice, do you do surgical procedures?

A Yes.

Q And these would be surgeries related to what?

A Well, all manners of gynecologic surgery, and then obviously cesarean sections to deliver babies, and other infertility surgeries to open the people's fallopian tubes and things of that sort.

Q And I assume you're licensed to practice medicine in the state of Texas?

A Yes.

Q Are you licensed in any other states?

A No.

Q Now, as far as what you actually do in your medical practice, do you do medical procedures which involve removing a live fetus from the uterus?

A Yes.

Q And do you do medical procedures which involve removing a dead fetus from the uterus?

A Yes.

Q And are there lay terminologies that apply to removing a [p. 236] live fetus from the uterus and removing a dead fetus from the uterus as far as what you do?

A Right. Obviously, removing a live fetus from the uterus is a vaginal delivery of a live baby. The removing of a dead fetus, that is considered the delivery of a fetal demise, is what that's called.

Q But as far as what you do, do you do abortions?

A No, I do not.

Q What you do would, I take it, wouldn't involve in the lay concept of a miscarriage?

A Exactly.

Q And when we are talking about a miscarriage or removing a fetus that's dead, when do you consider a fetus dead?

A I believe it's generally accepted the fetus is considered dead if the heart has stopped beating.

Q And that fetus would be considered alive, then, when?

A If the heart is beating.

Q And when you say generally accepted, generally accepted by whom?

A Physicians.

Q And when you are dealing with removing a live fetus from the uterus, what you do as far as delivering a baby, whose health are you all concerned about in that situation?

A Well, we are obviously concerned about the health of the baby and also the health of the mother.

[p. 237] Q And when you're dealing with a miscarriage situation, whose health are you concerned about?

A The mother.

Q As far as the number of miscarriages that you've attended or dealt with, do you have any estimate of the numbers you've dealt with?

A I don't have an exact number, but it's in several hundreds.

Q And as far as the gestational ranges of the fetuses that you've dealt with in miscarriage situations, can you tell us what the ranges would be?

A Anywhere from a barely recognized pregnancy at five or six or seven weeks all the way up to a fetal demise at 37 weeks.

Q And would you agree that as a general principle, removing a dead fetus is more complicated the more advanced the weeks are in gestation?

MR. HELLER: Objection; leading.

THE COURT: It is leading, but with an expert, I'm going to give some of that. Overruled. You may answer, Doctor.

THE WITNESS: It's well known that the more further along a pregnancy is, the higher the gestational ages, the more difficult the procedure.

BY MR. SMITH:

[p. 238] Q Are you generally familiar with the medical risks and complications involved in removing a dead baby from the uterus?

A Yes.

Q Are you familiar with the medical procedures that would be involved in removing either a live or dead fetus from the uterus?

A Yes.

Q And are you familiar with the generally-accepted medical procedures performing abortions?

A Yes.

Q Are you familiar with the medical risks and complications and contraindications associated with the performance of abortions?

A Yes.

Q And can you tell us how you are familiar with the generally accepted medical procedures, the risks and complications and the contraindications associated with abortions?

A Well, just from during my training, reading, keeping up with the American College of OB-GYN technical bulletins, reading in Williams Obstetrics and Gabbe Obstetrics textbooks, and from time-to-time in my training at Parkland Hospital, there were medically indicated abortions that were performed while I was there in training that, as my role as [p. 239] the chief or most senior resident in labor and delivery, I would have to come in a situation where possibly the night before, a drastic fetal anomaly had been discovered in the high risk OB-GYN clinic, and the mother wanted to go ahead and terminate the pregnancy as soon as possible, so they would go ahead and start it that evening. By the time I took over the next day, it would still be going on, so I'm acquainted with what goes on.

Q And have you, in your practice or in your experience, for that matter, been involved with just treating patients who have been previously treated by physicians who have attempted abortions?

A Yes, I have a pretty extensive background there. Parkland Hospital is the county hospital in Dallas, and whenever there is a severe complication from an abortion attempted at one of the outlying abortion clinics, basically they send them to Parkland for us to fix.

Q Now, as far as the care that you would provide associated with a pregnant mother who intends to give birth to a child, do you – Does part of your care ever

involve injecting a needle into the uterus or uterine cavity?

A There is a procedure known as amniocentesis that is performed for genetic reasons early on in pregnancy, usually between about 13 and 18 weeks, and I have helped in those during my residency and performed those during my residency. [p. 240] Also, there are amniocenteses done near term to determine fetal lung maturation indexes to time the delivery of a planned C-section.

Q And the amniocentesis, can you tell us what the procedure actually is?

A Amniocentesis involves sonographically locating the position that you're going to attempt to put, place a needle. There usually, [sic] anatomically, nearly 100% of the time, 100% of the time in my experience, there is, when you're looking through the sonogram vision of the array of your field, you see the skin, the subcutaneous fat, the abdominal wall muscle, followed by pregnant uterus, okay? And what you do is a sonographic guided tap of the uterus with a very, very fine spinal needle, so what you do is, you have the transducer on the abdomen, and you after, you have sterilely cleaned the field with multiple rounds of Betadine –

Q The field being what? What is the field?

A The field is just a surgical field. Anytime you're doing an invasive procedure, you cleanse the area with Betadine and put sterile barriers around it so there is no – you lessen and nearly eliminate the possibility of an infection, and you put the sonogram in a sterile glove, and you place it on your sterile field on the patient's

abdomen where you're looking to find the place where you want to insert the needle, and then you watch, actually on the video [p. 241] screen, you watch where your needle is going, and you can see it perfectly.

Q And when you say the sonogram, is that what – How do you sonographically do that? Is there a name for the machine?

A Ultrasound machine. A sonogram is actually – I use the terms interchangeably, but it's an ultrasound machine, and the sonogram is the actual pictures you take.

Q And the amniocentesis, at least in your experience, has been performed at the weeks of gestation from 13 to 18 weeks?

A Oh, yeah.

Q And also later?

A Right.

Q And are there medical risks to the mother and to the fetus by doing an amniocentesis?

A Well, any time you do any type of invasive procedure, there are risks, but in the hands of a skilled operator, those risks are minimal. Your risk of an infection, say, from a genetic amnio between 13 and 18 weeks is about one in a thousand. The risk of an amniocentesis-related miscarriage overall is, and across the country and including in training centers where you know younger-level residents such as interns might be doing them, is one in 200 for all the different complications that can arise that might lead to a miscarriage. However, again, in

the hands of a skilled [p. 242] physician that has lots of experience, it's more like one in 800.

THE COURT: Mr. Smith, so you understand, the Court may not be clear that an amniocentesis is the same thing as injecting Digoxin into the fetal cavity, thoracic cavity, and if there is a difference, it would be helpful for the Court to know that.

MR. SMITH: I appreciate that. My questions, really, at this point, are more foundational with the expectation to get into that.

THE COURT: All right.

BY MR. SMITH:

Q As far as the risk that you've described from the amniocentesis, the risk of infection, if the risk turned into reality, in other words, the patient actually was infected, what's the complication, then, in just dealing with the infection?

A Well, what would happen, if a patient developed a severe infection from an amniocentesis-related infection, you, at that point, are going to do everything you can to protect the life of the mother, and depending on how severe the infection is would determine what you would do. If you get an infection inside the uterus that's a severe infection, there is going to be no way to really save the fetus, and so that would be considered an infected – basically an infected [p. 243] miscarriage that has been brought on by amniocentesis. Now, translating that and getting to the judge's concern, as far as procedure that's associated with an abortion which a physician would, through a sonogram or through the ultrasound, inject the

fetus or inject the, I guess, the fetal sac for a better term, with a substance in order to cause the fetal demise of the fetus, are you generally familiar with that type of procedure?

A I believe you're asking about like an installation procedure where they inject – would inject either hypertonic saline or hypertonic urea. I am familiar with that.

Q Would you be familiar with the procedure in which there would be an injection of Digitalis or potassium chloride in order to cause demise of the fetus?

A Yes.

Q Are you able to explain what differences, if any, there would be between that type of an injection procedure to cause the fetal demise for an abortion versus the procedure that you do which is the amniocentesis?

A The difference, to my knowledge, is that instead of looking for a clear pocket of fluid to remove fluid from, you would be –

Q And that's what you do in an amnio?

A That's what you do in an amniocentesis.

Q Go ahead.

[p. 244] A You would be looking for the fetal heart which is a pretty obvious anatomic structure on the ultrasound from – You can see it, ultrasoundwise, from five weeks on, but at, say, 13 weeks, 15 weeks, it's very obvious, and you're at any point past that, you are looking to put your needle, instead of into a pocket of fluid, like with an amniocentesis, you just direct it into the heart.

Q And if one wanted to cause the fetal demise other than by injecting into the heart of the fetus, do you have to hit the heart, I guess is what I'm saying?

A If you are looking to stop a heart by injecting potassium chloride or Digoxin, you need to hit the heart, yes.

Q Well, can you get an area within the uterine sac, I guess?

A Well, if you are looking to stop the heart, you want to inject the heart.

Q And at least based on your knowledge and experience, you believe that a skilled physician would be able to do that type of an injection and inject the heart at age 13 weeks on?

A Well, it's – The higher the gestational age, the easier it would be just because you're aiming at a large target but if you are – a larger target. But if you are looking at – if you restrict, yourself to 19 weeks and up, say, which is generally, if people are going to use that particular route [p. 245] to stop the heart of a fetus, that's generally when they do it, but could a person that was facile at instrumentation to do the procedure at 19 weeks do it on the 17th week or 15th week, the answer should be yes.

Q Thirteen weeks?

A You should be able to put it into the heart at 13 weeks, but that – I don't – That's not something that's generally done at that particular age.

Q Now, as far as the risk of doing the injection to cause the fetal demise, do you understand what I mean by that?

A Right.

Q Okay. Do you believe there would be a risk of perforating the bowel of the mother?

A The risk of perforating the bowel in an ultrasound guided procedure, whether it be amniocentesis or stopping the heart of a fetus, is virtually zero.

Q Is there a risk of injecting the mother rather than injecting the fetus?

A The risk of injecting the mother with Digoxin or potassium chloride in that procedure, in the hands of a skilled operator, would be inconsequential. It would be near zero as well.

Q Does it make a difference in doing the injection that ultrasound – Well, let me ask you this: Is ultrasound, would you agree, is a two-dimensional plane?

[p. 246] A It's a two-dimensional field, but it's an exquisite technology. I mean, everything is very clear. You're looking at a field produced in an array that lines up coming from the sonogram monitor in this direction to the sides, and the sonogram, the ultrasound head is approximately that big. The transducer you would use is approximately that big.

Q If you could, just for the record, the dimensions don't – won't appear in the court reporter's notes unless you give us dimensions that you showed with your hands.

A Oh, okay. I don't know the exact dimensions, but the dimensions approximately of the average sonogram transducer head, the one I use in my office, for example, would be approximately two – two to three centimeters wide by approximately eight to 10 centimeters in length.

Q And can you move what you describe the transducer head, can you move that around on the body?

A Yes.

Q So that you can increase the field by just moving the location on the body?

A You get a very clear picture of what's going on inside of a pregnant uterus by – as close as you can get to an actual three dimensional looking into the womb by moving the transducer around on the field, that's correct.

Q Now, as far as the questions I would ask you, the type of substances that could be injected into a fetus while it's [p. 247] in the uterus to cause fetal demise, what's your understanding of the generally-accepted substances that can be injected for that purpose?

A Are you –

Q And to create abortions, or do – associated with abortions.

A Are you speaking of actually into the fetal body cavity or into the fluid or both?

Q Any chemical agent to cause fetal demise?

A Well, the standard techniques that are injected where amniotic fluid is first removed and then replaced with a substance for what is considered an installation

technique of abortion would be a hypertonic saline solution which has been generally discarded. It's not used very much anymore. A hypertonic urea solution which may or may not be used with a Prostaglandin solution as well. Those are the main ones, and then if you are talking about injecting the actual fetal heart, Digoxin has been used in the past but is not considered the sine qua non of that procedure anymore. My understanding from speaking with several colleagues is that potassium chloride is the agent of choice at this time.

Q And as far as – Just from your knowledge, would there be contraindications, reasons that would you would cause a risk of harm to, the mother by injecting those substances into the fetus or the fetal area to cause fetal demise?

[p. 248] A Well, I would say that nothing is 100%, but in the hands of a skilled operator, you shouldn't run but a very small risk of any maternal complications from that.

Q If you had a mother who had a seizure, preexisting seizure disorder, would that be a reason why you would not do the injection to cause fetal demise?

A Not particularly, no.

Q Well, would it be a reason or not?

A No.

Q How about if the mother had preexisting heart disease?

A I would say that in a preexisting heart disease, if you are instilling something into the fetal heart to stop it

such as potassium chloride, followed by whatever procedure that you're going to use to remove the fetus from the uterus, the potassium chloride, in and of itself, would not be a contraindication due to her heart disease.

Q Now, the fetus is within the area known as the placenta, correct?

A No.

Q Tell us where it's at.

A The fetus is in the amniotic sac.

Q Okay.

A The placenta is attached to one aspect of the amniotic sac.

Q The question I would have is, if you attempted to inject [p. 249] a substance into the fetal heart to cause fetal demise, and you didn't actually hit the heart but you hit surrounding area and just injected the substance, what's your knowledge and understanding of the substances that you would use to inject it with that would essentially get into the mother's bloodstream? How can that happen, I guess is what I'm asking.

A Well, Digoxin, for example, if you injected it and you missed the baby and injected it into the umbilical cord or one of the, you know, placental vessels or something like that, it could potentially get into the mother. Whether that would cause – It would be a very rare state of conditions that that would happen in the hands of a skilled operator. It would be very rare that the amount of the drug that would be used would cause significant damage to the mother if that happened. I mean, my

assessment of that would be the potential for harming the mother, given a very limited set of circumstances, is pretty low. You would not want to ever inject potassium chloride into a mother because if you did that to any substantial degree, you might stop her heart, but again, in the hands of someone that is a skilled professional, the risk is miniscule.

Q How do you define a skilled professional or a skilled operator?

A Someone who has training in this field of performing [p. 250] these particular events and has performed them on a number of occasions.

Q Now, as a general proposition in performing an abortion, is there any medical advantage to the mother in injecting the fetus or killing the fetus in some manner by an injection prior to removing the fetus from the uterus?

A Medically speaking, I don't believe that there is any advantage to that. I mean, of killing the baby first, then removing it. I mean, in terms of advantageous to the mother, no.

THE COURT: Counsel, just so you understand, I understand that answer to say that there is no medical justification or reason for killing the fetus in utero for purposes of the maternal health.

MR. SMITH: You understood it correct, Your Honor. Frankly, the reason I asked the question is so the Court understands that I am attempting to present a witness that, in my view, is not biased.

THE COURT: I appreciate that, but I want you to understand what I understood the answer to be.

MR. SMITH: Okay.

THE COURT: Okay.

BY MR. SMITH:

Q Now, as far as medical procedures that would be common to abortions, would it be common performing an abortion that [p. 251] the physician would need to dilate the cervix?

A Yes.

Q And could you explain in performing abortions just what the problems would be presented in dilating the cervix over the gestational ranges increase and how those problems can be addressed?

A The ease of doing a procedure, whether it's an elective or a medically-indicated abortion, you have to dilate up the cervix. The cervix is usually – has a – the external os is usually relatively small, less than half of a centimeter at the most, and sometimes is small, in a girl that's never delivered a baby, as a pinhole. It can be very, very small, and so generally, what occurs, depending on the size of the pregnant uterus and the gestational age is that in, say, a very early pregnancy, anywhere from six to eight weeks or even as high as 10 weeks, you could just dilate the cervix with the use of dilators, surgical dilators Pratt and Hegar dilators.

Q Are these instruments?

A These are surgical instruments, right. They are blunt-ended, progressively larger dilators where you start out with a very small, thin instrument, and you progress your way up to the size where you would need

to have it to be able to insert a suction cannula to do a suction procedure of the uterus. Like I said, up through, say, 10 weeks gestation, [p. 252] you really shouldn't need much more than dilators. If you start getting up into 13 weeks, 14 weeks, 17-week procedures, you're going to need the use of what are called most people use laminaria which are dehydrated seaweed stems.

Q Let me ask you the questions as far as when you describe up to the certain point, 10 weeks or whatever weeks you used after that, you wouldn't use the surgical dilators. Is that correct?

A Well, there are surgical dilators that go up to very large sizes, and – but if you are going to be dilating the cervix over a very quick period of time, most people would say that once – and it's up to the person doing the procedure and it's up to what their experience is and what their training is – but if I were going to be doing a procedure, say, on a 10-week miscarriage where the baby has died or the fetus has died, I would use the dilators myself. If I had a 12- or 13-week, I would probably put laminaria stems in the mother.

Q Why would you do one thing at 12 and 13 and something else earlier?

A The metal dilators that are used for dilating the cervix, in most instances, most people would agree that if you are forcibly dilating the cervix more than about 1.2 centimeters, it would stand to give some substantial harm to the cervix if you are doing that quickly over the period of a [p. 253] few minutes versus allowing a patient to have laminaria placed in their cervix that are small and

then soak in the fluid from around the surrounding tissues, and they dilate slowly over a period of hours.

Q What's the risk created by the harm to the cervix?

A Well, the point that we're always concerned about is whether you may be inducing a cervical incompetence.

Q What is that?

A That is where the cervix integrity and strength has been damaged by some type of injury.

Q Okay. And what is the cervical integrity and strength needed for? Why do you want to try to avoid harming it?

A So that you would be able to retain, keep inside the uterus a pregnancy in the future.

Q In other words, the cervical integrity is necessary to keep the fetus in the uterus, is that accurate?

A Correct. Correct. Otherwise, you could sustain a miscarriage just simply because the cervix opened early, and in that case, you would have to undergo a more complicated procedure to sew the cervix called which is called cervical cerclage, you do those between, you need to, but if you don't need to, you certainly don't because you're introducing lots of other potential risk.

Q The laminaria, you indicated, if I recall you correctly, you would use that starting at 12 weeks, 13?

[p. 254] A I would, if a situation occurred where I was, say, a patient came in that was 12 weeks or beyond is when I would use laminaria, and I would use the

smallest number and the smallest laminaria I could to allow the cervix to open up to the extent where I could get that 12- or 13- or 14-week fetus out.

Q Can you just tell us what a laminaria is and how you use it and how it is effective?

A Laminaria are seaweed, I believe, Japanese seaweed, and they dehydrate them into little rods that are about four or five centimeters long, and they are attached to a string. What you do is you place them into a cervix, into the cervical external os and up into the cervix because you want to dilate the internal os as well, so that they are, once you put them in, the laminaria, you can see the end of the laminaria and the string in the vagina, but for the most part, the laminaria is inside the cervix, and what happens is, they are very dehydrated, and just like with any particular principle of where there is one dry area or dryer area or hyperosmolar area where there is – It draws fluid into it from the surrounding tissues, just a naturally-occurring event, and when that seaweed has been dehydrated, soaks up the fluid from the tissues around it, it becomes much larger, several times larger, and if you put in – If you are able to put in two or three small laminaria and they [p. 255] expand over a period of, say, eight to 12 hours, then you can place larger laminaria in, and then they would expand up to the point where you have the cervix opened to the extent where you can do the procedure you need to do.

Q And does the laminaria allow one to expand the cervix gradually over a period of time other than forcibly over a short period?

A Yes.

Q And what you ultimately are trying to do with the laminaria is just expand the cervix in order to get the fetus out, correct?

A Correct.

Q As far as medical risks to the mother and medical advantages, I'm going to ask you, is there a medical advantage to the mother in abortion by partially delivering the fetus alive, killing the fetus, and then completing the delivery?

A No.

Q Are there risks to the mother by a physician who would deliberately partially deliver a fetus alive, kill the fetus, and then complete the delivery?

A No.

Q My question was the risk to the mother from – by a physician who would partially deliver the fetus alive, then kill the fetus.

[p. 256] A Oh, the risk. I'm sorry.

Q Yeah. The first question was the advantage and the risk.

A I'm sorry. Would you ask that question again? I must have missed it.

Q Okay. Are there risks to the mother by the physician who is doing an abortion with deliberately deliver the fetus alive partially into the vagina, kill the fetus, and then complete the delivery?

A Okay. Okay. I'm sorry. Yeah, the risk to the mother are that, at that particular point, the fetal head is

within the uterus, and performing any procedure at that point, whether you would crush the fetal skull or whether you would do any kind of instrumentation, if you – such as piercing the back of the fetal neck at the junction of the skull and pursuing a suctioning event through the skull, you are still introducing into the vagina a sharp instrument, and if the head is still inside the cervix and inside the uterus, and that is still inside, then you are doing that blindly. In order to get in there, you are passing a sharp instrument –

Q Let me stop you. Why would you be doing it blindly if you have got an ultrasound?

A Well, because once you get that low into the pelvis, you are bumping up against the pubic bone, and your vision is going to be much different than if you are up on the abdomen [p. 257] doing an ultrasound. My understanding is, with this particular issue, is that at this point, the ultrasound is not of use, and what is is just manually feeling the area you're going to and placing your instrument in there.

Q What's the risk of doing the procedure in that manner or doing that blindly?

A Well, if you, anytime that you place any kind of sharp instruments into the vagina, you are going to be passing the anterior wall of the vagina, passing underneath the pubic bone on the anterior wall of the vagina is the urethra. On the other side of the wall of the anterior vagina is the bladder. Again, you're talking about also passing by the cervix and the cervix is supplied by vessels, and –

Q You mean blood vessels?

A Blood vessels carrying blood, and then into the cervix or the uterus.

Q Is the risk that you would perforate any of those tissues that you described?

A There is always a risk of that whenever you are placing a sharp instrument in there.

Q You believe the risk would be higher even for a skilled operator as a blind procedure?

A I believe that any kind of blind procedure, there is a risk regardless of how skilled you are.

Q Would you believe it's greater than if you are using a [p. 258] sharp instrument where you can see what you're doing with an ultrasound?

A Yes.

Q Is there a risk of harm to the mother, either removing a dead fetus from the uterus or – Well, strike that. Is there a risk to the mother in performing an abortion or when you're doing a miscarriage and removing a dead fetus from the uterus? Is there a risk to the mother posed by the fetal tissue in the uterus remaining in the uterus?

A If you allow fetal tissue to remain in the uterus, there is always a potential for bacteria from the vagina to get into the uterus, either at that time or later, that would cause an infection in the uterus. That is the largest risk.

Q And how does the physician deal with that risk?

A You would finish the procedure that you're doing. If you believe there is placenta left or fetal tissue of any kind left, you would follow up whatever procedure you've just done by a suctioning or sharp curettage of the inside of the uterus to be certain that there would be no fetal tissue left.

Q And in the hands of a physician who knows what he's doing, if he does perform the procedure to finish it, as you described, is there still a medical risk to the woman?

A It would be very very small, if any.

Q Are you aware of any general accepted medical principle [p. 259] or any medical literature or knowledge that the brain contents of a fetus would be toxic to the mother if they got into the mother's blood system?

A You don't want any type of fetal tissue, regardless of whether it's amniotic fluid, amniotic fluid embolus or fetal amnion tissue or placenta or fetal brain or fetal lung or anything else, you don't want that to get into the mother's circulation, but the brain is no more toxic than anything else.

Q Than the placenta or any of the other fetal parts?

A Right.

Q Now, as far as how you actually perform your medical procedures when you would remove a dead fetus in a miscarriage situation, where do you do those procedures?

A At the hospital in the operating room.

Q And is there any particular reason why?

A In my particular practice, and I believe most people's opinion, anytime that you are doing a procedure for removing a fetus from the uterus, there is a potential for complications to arise which you would need to be within a hospital setting so you could attack that situation very quickly and resolve it, mostly, especially in terms of a larger pregnancy past 12 or 13 weeks, the chance for maternal hemorrhage.

Q You could, if you wanted to, do the procedures in your [p. 260] clinic?

A You could.

Q You choose not to?

A Right.

Q And the reason is, you think it's safer in the hospital?

A Right.

Q And at least in your experience as a physician, you have had to deal with a situation where others have attempted abortions in the clinics, and then you had to deal with the complications when the mother was taken to the hospital, correct?

A Correct.

Q Do you understand what is meant by the term peer review?

A Yes.

Q Can you tell us what that means?

A Peer review is a situation where, within the hospital staff setting, colleagues, fellow physicians, are always scrutinizing the activities of another physician. This comes into a meaningful situation where there have been actions by a physician or complications arising from procedures by a physician that are out of the realm of the ordinary, and they are then marked by other personnel that something unusual happened or something unusual was done, and this is addressed by the particular physician's department within the hospital, by his colleagues.

[p. 261] Q Would it involve a process in which there would have to be justification for procedures then?

A Correct.

Q Now, what peer review is there in your clinic setting?

A If you are a solo practitioner in your clinic setting, there are no peers.

Q Are you a solo practitioner?

A Yes.

Q Do you have peer review in your clinic?

A No.

Q As far as the actual methods that you use in removing a dead fetus from the uterus in a miscarriage situation, what medical procedures do you use?

A From when a fetus or from when a pregnancy is recognizable and requires a D & C done, for example.

Q And if you could explain the terminology rather than abbreviations.

A I'm sorry. Let's say in a situation where there is observable fetal tissue greater than, say, six, seven weeks gestation in size, if a miscarriage or what's called a missed abortion occurs where the fetus is dead and remains in the mother, does not miscarry spontaneously, from that point on up through 13 weeks, I would do what's called a dilation and curettage, or a D & C is another term for it, a short term, where I would dilate the cervix, again, as gently as possible [p. 262] in the operating room, to the point where the appropriate sized suction curette could be placed into the uterus and perform as gentle a procedure of evacuating the uterus of the fetal tissue at that point as possible.

Q What's the mechanism for evacuating?

A I'm sorry. The mechanism?

Q What mechanism for evacuation of the fetal tissue?

A You would use, for the majority of the fetal tissue, a suction curette which is – Well, a suction curette is a typical sizes – different sizes, and they range from small to large. The typically, you're going to be looking at a curette that is seven or eight millimeters up to 12 millimeters at the most. Most of the time when I'm doing a suction procedure of the uterus where a curette is introduced, it's approximately the size of the end of this pen or a little bit larger which is usually about an eight or a 10 millimeter curette widthwise.

Q I interrupted you. If you could just go ahead and continue to describe the medical procedures.

A Well, I dilate the cervix to the point where I can put in the appropriate size curette, and then you put the curette in with no suction at that time, and then you close – The suction is on, but it's open to the air on the outside, so it's suctioning air out, and then you close that, and it creates a closed suction environment inside the uterus and [p. 263] very effectively sucks the fetal and placental tissue in. In the particular instance of a missed abortion where the tissue has not come out on its own, it's more difficult than, say if a patient were in the middle of an incomplete abortion where some of the fetal tissue has already come out, and that's an easier procedure than having to go in and take it out. Usually there is some trailing placenta or fetal membrane tissue that is left following a suction procedure, and so it's usually advantageous to clear the remains, go around the uterus one time with a sharp curette as gently as possible to make sure that the tissue is completely out, and that's the procedure.

Q Okay. Then in more advanced stages of gestation, what procedures would you use?

A After 13 weeks, you would perform what's called a dilation and evacuation, D & E for short, for the removal of the fetus where you would basically dismember the fetus. Most of the time when you're dealing with a fetus that has already died, and it has been usually two or three weeks between visits where the patient has felt or you've observed the fetal heartbeat, either with a Doppler or an ultrasound. The patient comes back in, you can't find the heartbeat. It has usually been the period of about four weeks, and the patient is not to the point yet where they would notice fetal movement, and so the baby

has been dead for a few weeks by [p. 264] the time you see it. When that takes place, the fetus in many circumstances is very apt to start basically falling apart when you're trying to remove it from the uterus, and what you would do at that point is make sure that you have every part of the fetus. You reassemble the fetus on a surgical what's called a Mayo stand or a surgical stand on your operating room or table and make sure that you have all the fetal body parts and a placenta.

Q Now, is there at some point in the gestational age when you would be removing a dead fetus that you don't use the dilation and evacuation procedure?

A In my particular practice, if a fetus is larger than 16 weeks, and some people go 18 weeks, other people who in the field go as far as 20 weeks.

Q And would any of those judgment calls, would it be within generally-accepted medical standards?

A Right, but you're talking about a 16-week or larger fetus. Would – You would consider doing what's called an induction procedure on the patient where basically you put in laminaria again, the same particular procedure I described before, and then instead of proceeding to a procedure where you would remove the baby with a suction and sharp curettage or dismembering the fetus, you would put the patient into labor either with intramuscular Prostin or a Prostin vaginal suppository or high dose Pitocin intravenously.

[p. 265] Q And then just go ahead and tell us what happens.

A Basically, you put the patient, you shorten the time that the patient would be in labor by dilating the cervix up to a particular point with the laminaria. You take those laminaria out, and usually if you've gotten the cervix up to the appropriate size, the fetus, it doesn't require much in the way of a long protracted labor to get that fetus to deliver because they are usually still pretty small, and you would do just a medical induction of labor with the agents I described before, whichever you chose to use.

Q When you start the process, are you able to predict or determine when the actual delivery would occur?

A Predict? You can't predict exactly when it's going to occur, no.

Q And that was what I was trying tc get was the time frame that you would be talking about once you would introduce the Prostaglandin from the time you would reasonably expect a delivery or an expulsion of the fetus?

A You can't predict it with any certainty, no.

Q Is there a range of time you would reasonably expect?

A I've seen women who actually went into labor just from laminaria being placed and delivered a baby either at home or on the way to the hospital all the way to it taking eight to 12 hours has been my experience, so it can happen either before you intend for it to or later.

[p. 266] Q Now, as far as the induction procedures you've described, is that procedure contraindicated if the

mother has heart disease, diabetes, renal disease or prior C-section and C-section meaning prior cesarean section?

A If – if there were any – In most of those – Would you please repeat the particular conditions?

Q Let's take them one-by-one.

A Okay.

Q Would the induction procedure be contraindicated or something you would not – that's not recommended that you use in a situation of a mother who has had heart disease?

A It depends on what the heart disease is.

Q And can you explain that?

A Well, it depends on how severe the heart disease is, and you – In any kind of heart disease, a labor process is likely to increase the cardiac output and the work the heart has to do, so if you have any question of whether you're going to potentially harm the mother by putting her into labor, then again, in the hands of a skilled operator, there are people that do D & E's past where I do them, and if I had a baby that was that large with a mother with virtually any of the complications you just described, I would be passing them on to a high risk obstetrician in a formal high risk center.

Q Would you be doing that in the clinic setting?

[p. 267] A No.

Q Now, as far as gestational age, how do you determine the gestational age of a fetus?

A Well, the gestational age is determined, the first way that you do it is by looking when the lady's last menstrual period started. That's considered the gestational age.

Q How do you know when that was?

A Just by her history.

Q What she tells you?

A She tells you.

Q Okay. Go ahead.

A A significant amount of time, what she tells you and what you see sonographically by the ultrasound are two different things. Then you've got a conflict of what your gestational criteria are, but with very early ultrasound, such as in my office, I use a vaginal probe ultrasound is one of the transducers I have on my machine which you can do a crown to rump link on a baby very early on.

Q Crown to rump link. Are you referring –

A The head to the butt.

Q Of the baby?

A The head to the butt, that's right.

Q Okay. Go ahead.

A You would do the crown to rump link on the baby which will tell you virtually within days of how far along the baby [p. 268] is. If that does not match up whatsoever with the last menstrual period, then you take that as your criteria, or if the woman is the least bit

uncertain, then that is your best criteria because you have got it within days. Past 13 weeks, it gets a little bit more difficult. Different factors come into play. The size of the baby is, even ultrasoundwise, is not as precise after 13 weeks, and if you get past 16 weeks, you're going to be dealing with plus or minus one to two weeks, and you're way off, you can be, from that point you can be three to four weeks, you know, distance around the particular gestational age is a factor there, so reliably, in order to tell a – how far along a lady is, the best indicator of how far along a baby would be would be to having an early, prior to 13-week vaginal probe ultrasound early in the pregnancy.

Q And if you don't have that, would it be accurate, the way you would make the determination, as relying upon what the mother tells you on her last menstrual period and the ultrasound?

A Right. You just try to get your best, you add up what you've get and get your best guess after that.

Q And your best guess or estimate can be off plus or minus how much?

A Two weeks.

Q Is there a point in time of gestational age in which it [p. 269] is generally recognized in the medical profession that fetuses are not viable, if you know?

A Are not viable?

Q Are not viable.

A Under a certain age?

Q Yes?

A Viability is a concept which has changed significantly since I have been in medical school. It is generally accepted that a fetus is considered viable by most experts at 22 to 23 weeks at this point.

Q And of those that are considered viable at 22 to 23 weeks, that doesn't mean all of them, correct?

A Correct.

Q It just means at 22 to 23 weeks, you do have a percent that you would expect would be viable?

A Correct, and, you know, the earlier, the less chance that they would have to be viable and the later, say, you know, 29 weeks, the greater chance to be viable.

Q And that assumes the determination of the weeks of the gestational age is accurate, correct?

A Correct. You can have vast differences that I have personally seen where a fetus measured much smaller, and the computer on the ultrasound predicted that the baby's age was much smaller or much earlier than it actually was. In my training at Parkland, there was a baby that was born alive [p. 270] that appeared to be very early, and back then, in the late 80's, '88, '87, '88, 25, 26 weeks was the edge of viability at that point, and this baby appeared so small that it couldn't have possibly been any further than about 22 or 23 weeks, and what was done was, the baby was born alive, but because it was so small, there was no chance it could survive, so it was left over on a stand in the delivery room basically to die because it couldn't live at that size. When the baby was still over there on its own moving around and

breathing 30 minutes later, they determined to call the intensive care unit and get the baby over there, and as it turned out, that particular baby was a victim of what is called intrauterine growth retardation, and due to what was thought to be maternal hypertensive disease, was much smaller than it should have been, and the maternal stress had caused the baby to mature much quicker even though it was much smaller, and I know for a fact, I don't know what ultimately happened to that baby, what its intact survival was or whether it survived long term, but I know for a fact that baby was alive for several weeks, so size and what a sonogram can tell you is not perfect.

THE COURT: Let me inquire of plaintiff's counsel, plaintiff makes no contention that plaintiff has the right to do post-viability – Post-viability abortions are not an issue as asserted by the plaintiff, is that true?

[p. 271] MR. HELLER: Your Honor, plaintiffs – Well, I don't think this case involves the issue, but certainly, plaintiff intends to abide by the Nebraska statute which prohibits the performance of post-viability abortions unless necessary to protect the woman's life and health, and I think plaintiff's testimony was, he doesn't do abortions after viability.

THE COURT: Well, what I'm asking you is, there is – Plaintiff does not contend that he does post-viability abortions?

MR. HELLER: That's correct.

THE COURT: And that this statute somehow interferes with his ability to do post-viability abortions.

MR. HELLER: That's correct, Your Honor.

THE COURT: All right. Thank you.

MR. SMITH: Just so the Court understands, the latter portion of the testimony on viability, my purpose for introducing that was really directed at impeachment of Dr. Carhart's qualifications and expertise. That was the purpose for it. I do have a couple of questions, and I will conclude with Dr. Riegel.

BY MR. SMITH:

Q Dr. Riegel, as far as the concept of peer review at the hospitals where you have privileges, does peer review go on there?

[p. 272] A Yes.

Q At all of them?

A Yes.

MR. SMITH: Nothing further.

THE COURT: Counsel?

CROSS-EXAMINATION

BY MS. WALZ:

Q Yes, I have, excuse me, just a couple of questions, Dr. Riegel. I believe when you were speaking before, you talked about how after about 13 weeks gestational age, you use the D & E procedure?

A Um-hm.

Q At 16 weeks and higher, you go to the induction procedure?

A That is what I do. There are overlapping methods of doing these particular things, these particular procedures. Some physicians would like, some high risk physicians, people that are trained and have done a four-year residency in OB-GYN, then two or three more years in nothing but high risk obstetrics would feel more comfortable still performing D & E's or evacuations after the point where I feel comfortable doing it. In my particular setting, the mode of practice among the physicians that I work with is about 16 to 18 weeks, you would perform an induction.

Q And why is it that you and these particular people that [p. 273] you practice with decide that at that point you prefer not to do a D & E anymore?

A We believe that the D & E might be somewhat riskier at that point than the induction would.

Q How is it riskier?

A The D & E is riskier than an induction because you are placing instruments into the uterus, and there is potential for harm to the mother, more so than if you were performing an induction where you just, the baby would deliver, and then if the absolute worst case scenario, you might have to do a curettage of the uterus to get placental fragments out or something like that.

Q But part of the induction procedure doesn't normally include the introduction of these instruments into the uterus, isn't that correct?

A Correct.

MS. WALZ: Thank you. I have nothing further.

THE COURT: All right. It's now about 10:48. May I suggest we take our mid morning break of about 15 minutes? Does the doctor have airport, is he going to get to the airport at 2:00?

MR. SMITH: He needs to be out of here at 2:00.

THE COURT: We can do that, can't we?

MR. HELLER: I believe we can, Your Honor.

THE COURT: Well, we will. Fifteen minutes.

[p. 274] (Recess from 10:47 to one 11:04 a.m.; all parties present)

THE COURT: Have the defendants concluded their examination of the [sic] this witness?

MR. SMITH: Yes, Your Honor.

MS. WALZ: Yes, Your Honor.

THE COURT: You may inquire.

CROSS-EXAMINATION

BY MR. HELLER:

Q Thank you, Your Honor. Dr. Riegel, is this the first time you've testified in court?

A Yes.

Q Have you provided affidavits in cases or sworn written testimony in court before?

A I've never been in court before.

Q You indicated in your testimony that you don't perform abortions, is that right?

A Correct.

Q And what is the reason that you don't perform abortions?

A I choose not to perform abortions due to moral objections.

Q Does your – does your practice include provision of birth control, prescription birth control?

A Yes.

Q You also testified a little bit about your background and experience. Have you had any academic appointments?

* * *

[p. 276] Q You weren't involved with any dilation and evacuation abortions for medical indications as you prescribed them, is that right?

A No, not myself.

Q Did you observe any at the Parkland Hospital?

A I have seen some going on. I didn't directly go in and stand behind them and watch them, no.

Q You have seen them going on. You were aware they were going on?

A Right.

Q What stages of pregnancy were the D & E's performed at Parkland Hospital?

A To tell you the truth, my experience there is so limited, I can't even tell you. Generally, if I saw a procedure going on, from my moral, particular personal

moral [p. 277] view, and I chose, just other than the ones that I had to take over out front, the inductions going on, I chose not to be associated with them.

* * *

[p. 279] Q You gave some testimony about injections. I think you talked about amniocentesis?

A Um-hm.

Q That you performed, is that right?

A I have performed them in the past, yes.

Q On how many occasions have you performed amniocentesis?

A Several. I have no idea of knowing how many.

Q Do you think it's a hundred?

A Probably somewhere between 50 and a hundred.

Q What's the purpose of that procedure when you do it?

A Amniocentesis is performed early at 13 to 18 weeks of gestation for genetic diagnoses.

[p. 280] Q So is it because the woman requests it?

A Correct.

Q And it's an elective procedure?

A Correct.

Q You certainly wouldn't ever do amniocentesis if the woman didn't want it, would you?

A No.

Q When you do amniocentesis, you describe some of the risks that could be present, like risk of infection?

A Yes.

Q Do you inform them of that risk?

A Yes.

Q Do you inform them of any other risks during amniocentesis?

A Yes, there is always a risk of, even though it's small, of bleeding during the procedure. You could inadvertently nick an umbilical cord vessel or a placental vessel, or you might hit a sinusoid going through the uterine wall which could start bleeding, and then, of course, you give them the overall, what was touted as the overall miscarriage rate related to amniocentesis. In teaching institutions at the time that I was involved with these was about one in 200.

Q In the amniocentesis procedure you perform, am I correct that you are withdrawing some fluid?

A Correct.

[p. 281] Q And are you withdrawing it from inside the fetus or the fluid around the fetus?

A The amniotic sac.

Q That's around the fetus?

A Correct.

Q You're not injecting anything into the woman?

A No.

Q How – Let's take the example of 16 weeks. How large is the fetus at 16 weeks?

A How large?

Q I realize that's a little unclear. If you were to measure the fetus from one end to the other, how would – What would you estimate the size to be?

A Well, I happened to see a 17-week fetus a few weeks ago. The lady miscarried and the fetus was from head to foot probably – I didn't measure it – but probably 10, 8, 9, 10 inches.

Q At 17 weeks?

A This one, it was about this big, the one that I just saw a few weeks ago.

Q Are you aware that the State of Nebraska publishes a booklet that says that at 17 to 18 weeks, the fetus is five-and-a-half to six-and-a-quarter inches in length?

A Well, again, these are – I'm looking at a fetus in a pan that I did not measure, okay. I don't measure foot to – [p. 282] There is no reason to measure and know a way to measure foot to head measurements of a fetus. Even when you're doing ultrasound, there is no measure. I was telling you those are approximations but I'm just looking at what I saw, and I'm guesstimating at what that is. I don't know what the State of Nebraska published, no.

Q Well, I may show you this in a minute regarding some other questions. Do you know from your training or experience what the size of the length of a fetus is at 16 weeks in centimeters?

A That is not – That is something that is available to be studied if you desire to. It is never something that I have ever been tested on or note that nobody has ever asked me about, and so therefore, I don't have all of the inches measured at particular gestational ages in my lexicon of knowledge at this time.

Q I understand that. I'm asking for information that ordinarily you have access to a book or chart maybe to look something up?

A Correct.

Q What I'm trying to get a sense of is, let's say at 16 weeks, do you know what the size of the fetal heart is?

A I can't tell you exactly, no. I know what it looks like on an ultrasound machine.

Q Well, I want to give – get an idea of how large of an [p. 283] object, if you were injecting into the fetal heart, how large of an object.

A It's small. I can't tell you exactly how large it is. Usually when you're looking through an ultrasound machine, you magnify it several times.

Q Do you have any idea from your training if it's larger than one centimeter in size at 16 weeks?

A I can't tell you at all exactly how big it is in size, and anything that I would say, I would be guessing, so I'm not going to say anything.

Q You would agree, though, that the size of the fetal heart is much smaller at 16 weeks than the size of the amniotic sac, wouldn't you?

A That's obvious, yeah.

Q Might be 50 times smaller?

A Right.

Q So it might be significantly easier to administer or to get the point of a needle into the amniotic sac than it would to get it into the fetal heart?

A It would be obviously easier to get it into the sac than the fetal heart.

* * *

[p. 285] Q You gave some testimony saying that, talking about the risk in an injection of perforating bowel, and you said it was a virtually zero, and I want to ask you what the basis is for your opinion that it's virtually zero risk?

A In anytime that I have ever looked into the – through a sonogram, and again, many, many of these, plus discussing this with other experts in the field, high risk obstetricians, there has never been an incidence where there was bowel in front of the uterus where you were attempting to do an amniocentesis. I have never seen that.

Q So you are talking about anecdotal reports, your own experience and those of colleagues?

A Right.

Q How many cases do you think you've heard about?

A Where the bowel has been punctured?

Q No, no. You said you hadn't heard any of those. I'm just trying to get a sense of how many. Was it 50 or a hundred or a thousand?

A If you are talking about extended, hundreds.

Q And so out of some hundreds, you haven't heard of a [p. 286] single case of perforated bowel?

A Correct.

Q But you don't know of a statistical study that says the risk is one in a thousand?

A No, I do not.

Q And you said the risk of injecting the mother was inconsequential?

A It's very small as well.

Q Is that again based on sort of anecdotal information you have rather than statistical study that was done of how often that occurs?

A Correct. I'm talking about my own experience and what I've heard, and I have numerous friends and colleagues that are high risk obstetricians.

Q So it would be one in a thousand?

A I don't know what the number is. It's going to be very, very small.

Q I'm trying to get a sense of when you say very small, do you mean more like one in a thousand or one in a million?

A Probably more in line of one in a thousand, but I don't know what the number is.

Q You said you had spoken, I think you said you had spoken to some colleagues who said that potassium chloride would be the agent of choice in trying to induce fetal demise. Do you recall that testimony?

[p. 287] A Yes. I recently spoke with a colleague who is at a major university medical center, high risk obstetrician, who said that.

Q Is that someone who does that injection of potassium chloride into a fetal heart or fetus?

A I don't know whether he personally does or he does not. I know that some of the methods of terminations he has taken part in in the past, I have no idea whether he's actually done KCL injections, potassium chloride injections in the heart before.

Q Do you know what stage of pregnancy KCL injections are used?

A I know they are usually considered in the late term. Late mid trimester abortions is my understanding.

Q What do you base that on?

A Just from what I've read.

Q Where have you read that?

A Limit of actually probably the ACOG technical bulletin that was put out in '87. I think I read it possibly there.

I'm not 100% sure where I have read it. I know I have read it I have read so many things, I can't tell you exactly where, but my understanding is that that is done later.

Either the AGOG technical bulletin or some other publication or textbook.

Q What's the risk to the woman if the potassium chloride [p. 288] is in that maybe one in a thousand or, say, maybe one in 10,000 chance that the injection goes into the woman instead of the fetus?

A I don't – Whenever you have potassium chloride, I'm not sure exactly the amount that's injected into the fetus, because I have never taken part in that. That information is not something that comes across my desk ever. I don't know the exact amount, I don't know the exact amount that that what would cause a fetus's heart to stop would do to a mother. You would obviously never want to inject potassium chloride into mother regardless of the amount?

Q Why is that?

A Because potassium chloride can stop the heart. That's why you're injecting it into the fetus, but I have no idea how much a fetal dose would do to a grown woman. I don't know.

Q Do you know if potassium chloride can pass, say, through the umbilical cord to the woman?

A I would say that the chance of that occurring due to the fact that as soon as you inject potassium chloride into the fetus's heart, it stops, is very, very small.

Q I was asking a different question. Suppose by accident that the physician injects not into the heart but into the umbilical cord. Could go into that the woman's circulation pretty readily?

[p. 289] A I don't know whether potassium chloride – I don't know is the answer to that. I don't know.

Q Is there some mechanism that, in general, prevents substances that are in the fetal blood system from passing to the woman's blood system?

A Some substances do pass, some substances do not pass. Digoxin, you can give to a mother to change the rate of a baby's heart, so it does pass. You do not give the mother potassium chloride, and therefore, I've never come into contact with that, and I don't know the answer to it.

Q Would you agree that whether a substance passes depends on the size of the molecule?

A Molecule, correct.

Q Isn't potassium chloride a pretty small molecule compared to Digoxin?

A I'm not certain what the molecular size of this is. Again this is not information that even a high risk obstetrician is going to have at his fingertips.

Q I understand, but I mean, for example, potassium chloride, you would agree is two atoms potassium and chloride?

A Right. It's small.

Q It's small. I mean, I just wanted to see if it's pretty small. Is Digoxin a small molecule, do you have any idea?

A I have no idea exactly what the size of Digoxin is. I [p. 290] know it crosses the placenta.

Q You talked about the risk to the cervix of cervical incompetence from dilation. Is that risk the same when you use metal rods and when you use laminaria?

A Nobody knows 100% what the mechanisms for cervical incompetence is, and the reason for that is that some women who have never had anything done to their cervix have cervical incompetence, and other women that have had several abortions apparently don't, so we're not sure exactly what it is.What I'm addressing is the risk factors involved, and it is generally thought among obstetricians that if you quickly dilate up the cervix with metal rods, it stands more of a chance of damaging the cervix than if you slowly dilate them with laminaria.

Q So using laminaria is generally believed to be safer than the metal rods dilation?

A Generally, but again, that is just basically based on common sense principles, and there is no documentation of that that I'm aware of.

Q And – Nor is there any documentation, for example, that the insertion of laminaria causes cervical incompetence. There has been no study that shows that, as you indicated, that the use of laminaria for women who have had laminaria inserted, she is more likely to experience cervical incompetence?

[p. 291] A Anytime you put anything into a cervix, it is a risk factor for possible future incompetence. That is not to say that a lady who has had three elective abortions using nothing but Hegar dilators, followed by another elective abortion using laminaria, is going to

have a future cervical incompetence. You cannot predict that.

Q Because there could be other factors probably?

A Right. There's probably factors that we're unaware of at this time.

Q You testified that if a fetus were delivered intact or removed intact feet first, I think is the procedure you were talking about, that there would be a risk to the woman because in crushing the skull or piercing the neck, you would be inserting a sharp instrument into the vagina, is that right, or into the cervix?

A There is – In doing what I have read is this D & X or intact dilation and extraction procedure where the fetus is delivered up to the point of the head still being inside the uterus slash cervix area, that is not something that with the fetus being in the vagina is immediately visible to you, and so part of what you're going to be doing is going to be inserting sharp instruments into an area where you are feeling versus being able to see, and my point was that whether you are doing a D & E dilation and evacuation procedure where you are dismembering a fetus with sharp [p. 292] instruments inside the cervix, or whether you are doing a D & X procedure where you are cutting a hole, ostensibly, inside the cervix, you're still passing sharp instruments through the vagina where you could damage the urethra, the bladder, the vaginal wall, the cervix, into the uterus.

Q I understand. Do you insert sharp instruments more when you dismember the fetus?

A Usually, it has been my experience that the fetuses that I have been involved with usually dismember on their own.

Q Well, yeah, but those are dead fetuses?

A Correct.

Q Would live fetuses –

A My understanding is that live fetuses can often break apart too because their tissues are very soft.

Q What about a fetus at 19 weeks? Would the fetus readily break apart if it was alive at that stage?

A I'm not certain of the answer to that, but my feeling would be probably not.

Q So you might have to do more surgical insertion of surgical instruments into the uterus to dismember that fetus, is that right?

A That would make sense.

Q Than you would if you just had to insert once to crush the skull. Doesn't that make sense also?

A Well, my understanding of that procedure is that you do [p. 293] – You pass more than once into the uterus, but you do go back in to do the skull.

Q What I'm trying to get a sense of is, isn't it true that in a later abortion where the fetus is alive, let's say after between 16 and 19 weeks where it's less likely to come apart.

Q Um-hm.

A That in dismembering the fetus and removing it in pieces, you are more likely, you are going to be inserting sharp instruments on more occasions than if you remove it all in one piece. Doesn't that just make sense?

A That's true, but in my experience, and the experience of the people that are friends of mine that have done that, in the hands of a skilled operator, the difference, the incidence of complications from that are relatively small.

Q How many times have you removed a dead fetus at 19 weeks?

A Nineteen weeks.

Q Yeah.

A Removed it with a D & E procedure? I don't do them at 19 weeks.

Q Okay. So you said you wouldn't do a D & E procedure after about 16 weeks?

A Sixteen to 18. It just depends it depends if a lady is gestational age of 18 weeks but the fetus measures 16 weeks, then I would do it.

[p. 294] Q Well, how many times have you done that at 16 weeks? How many times have you done a D & E?

A Several. I don't know the exact number.

Q Less than 10?

A Probably more than 10, less than a hundred. I don't know the exact number. Probably more like if I was guessing, it would probably be 10 to 20 times.

Q Over the course of your career?

A Um-hm. It doesn't come up very often.

Q Well, I understand. I'm just trying to get a sense of how often it comes up because that is going to affect your assessment of what the risk factor is. If you do it 10 or 20 times and nothing goes wrong, you may feel as if the risks are very low, but if you were to do it more times, more likely you could see that risk that only happens once in a hundred times, wouldn't you agree?

A I know from the numbers that are presented in the literature that the risk is low.

Q I want to show you Exhibit 7.

A What's that? Exhibit 7. Oh, okay.

Q Yeah. Have you seen that document before?

A Yes, I have.

Q Could you turn to page 8 of this document?

A Okay.

Q And the last paragraph on this page discusses the intact [p. 295] dilation and extraction procedure. Do you see that paragraph?

A Yes.

Q And the second-to-last sentence says, "This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs." Do you see that statement?

A Correct.

Q Do you disagree with that statement?

A I believe that "may" is the operative word there, and I believe that depending on who the person that would be doing it would – The experience would be much different among different people.

Q And that reflects the fact that the safety of the given procedure depends on how often the physician may have done that before, what experience they have in doing the procedure, is that right?

A That's correct, but this particular procedure is not a recognized procedure in any medical text or database that I can find. This is the first document that I've ever seen that even refers to it in print aside from the newspaper. This procedure, in my four years at Parkland, was never even discussed, talked about, intimated, brought up among the best obstetricians in this country.

Q Well, now, you hadn't heard of this procedure before you read this document?

[p. 296] A No, I've heard about it in the press. The way I was informed about this procedure is in the press, in the lay press, and then I started hearing about it in the medical press and in any medical textbook or database of any kind, aside from this is the first time I have ever seen this in a medical – in anything related to medical procedures, and it's because the lay press and the people that perform this procedure coined the term intact dilation and extraction.

Q Isn't that what it is? You dilate and extract, intact, the fetus. Isn't that what the procedure is?

A Yes, but that is not a recognized medical procedure is my point.

Q Until this document?

A Until they refer to it in this document. Again, unless that procedure is being taught at major medical institutions and is subject to peer review, it is not a medically-accepted procedure.

Q That's your definition of what a medically-accepted procedure is?

A My definition of a medically-accepted procedure is that it's something that is performed under the scrutiny of other physicians and is an accepted practice amongst physicians.

Q Well, but abortion isn't an accepted practice at all to you, is it?

A That doesn't have any bearing on what is accepted among [p. 297] other physicians. That is a personal belief of mine.

Q Well –

A And it also does not affect the way that I look at abortion.

Q Would you agree with the statement that from the American College of Obstreticians and Gynecologists this is the definition, dilation and evacuation is a generic term that encompasses cervical dilation followed by evacuation of the products of conception. Do you agree with that definition of dilation and evacuation?

A Yes.

Q Is dilation and evacuation an accepted medical procedure?

A Yes, but this isn't –

Q Well, let me –

A This is a totally different thing. Find this in a medical textbook.

Q What makes in [sic] totally different?

A Find it in a medical textbook.

Q What makes this totally different?

A What makes it totally different is that amongst accredited physicians and experts in the field, it does not exist. That's what makes it different versus every other type of D & E, every other type of induction procedure for abortion, everything. This does not exist.

[p. 298] Q What is the basis for your opinion that it doesn't exist among accredited physicians or doctors?

A Williams Obstetrics is published where I was trained. It's considered one of the Bibles of obstetrics. It's not there. It's not in Gabbe's Textbook of Obstetrics. It's not in the prolog you study for the boards. It's not in any textbook because I have looked for it.

Q Have you looked for a procedure called craniotomy?

A Yes.

Q Is that in Williams Obstetrics?

A Yes.

Q Would you describe that procedure?

A It's – A craniotomy means that you poke a hole into the cranium.

Q Isn't there a procedure described in Williams Obstetrics whereby a fetus is removed, the after-coming head is too large to fit through a cervix?

A That can exist in a number of different forms.

Q Isn't that what this procedure is?

A No.

Q What's the difference?

A The difference is that in most cases of what you're talking about an enlarged after-coming head such as in a condition of hydrocephaly or hydranencephaly, you insert a tiny spinal needle through the abdominal wall to remove the [p. 299] excess fluid and deliver the baby. That's called cephalocentesis.

Q Through the abdominal wall?

A Through the mother's abdominal wall and into the uterus because it's a large head. That's called cephalocentesis.

Q Into the fetus's head?

A Yeah.

Q I'm just trying to get a sense of what is it about the definition of dilation and evacuation as I read it to you that indicates a physician is supposed to dismember the fetus?

A That is the accepted way that a dilation and evacuation and the only way I've ever heard of a dilation and evacuation being discussed or written about until this came into the lay press, and again, this is not an accepted mode of dilation and evacuation, and, in fact, I can quote the American College of Obstetricians & Gynecologists say they can, they say that they cannot imagine a particular time when this particular procedure is the preferred mode of delivery. That's paraphrasing what they said in their committee opinion or whatever that little thing was where this was the only mode that was available or the preferred mode something to that effect.

Q I'm going to show you a document that hasn't been marked. I think this may be the one you're referring to.

[p. 300] A It is. It's right here on the second page.

THE COURT: Counsel, I believe that has been marked, and I believe it's Exhibit 19.

MR. HELLER: Well, we had marked –

THE COURT: It has not been offered.

MR. HELLER: We had marked something else as Exhibit 19. This, if we want to mark it, I don't think we will. I just wanted to give it to the witness.

THE COURT: Go ahead.

BY MR. HELLER:

Q That's the document you're referring to?

A Um-hm, yes, it is.

Q What is that document, that paragraph on the second page say about this procedure?

A It says the terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by American College of OB-GYN could identify no circumstances under which this procedure as defined above would be the only option to save the life or to preserve the health of the woman.

Q Would you continue, please?

A An intact D & X may be the best or appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor in consultation with a [p. 301] patient, based on the woman's particular circumstances, can make this decision. Potential exists that legislation prohibiting specific medical practices such as the intact D & X may outlaw techniques that are critical to the lives and health of American women and the intervention of legislative bodies and the medical decision making is inappropriate, ill advised, and dangerous.

Q I take it you disagree with parts of that paragraph?

A The American College of Obstetrics and Gynecology is an organization that puts out certain opinions. Those opinions are influenced by the people who have made their way to the top of the American College of OB-GYN, and I can tell you without question that this particular procedure amongst the Fellows of a [sic] the

American College of OB-GYN and board certified OB-GYN doctors who are not of the American College of OB-GYN disagree with that statement.

Q Did you take a vote of the college?

A I didn't take a vote of the college. I'm talking about my experience in Dallas, Texas, with people who mostly are pro-choice.

Q I'm [sic] just want to be clear. You didn't poll the American College of Obstetricians and Gynecologists?

A No, I never said I did. I'm talking about my experience in Dallas, Texas. -

Q With people you know?

[p. 302] A And with the American College of OB-GYN. This is not the opinion of the rank and file American College of OB-GYN member.

Q Just based on your speculation or guess?

A Based on my experience which is all I can testify to.

Q Do you use intramuscular injections of Prostaglandin?

A Yes, I have.

Q Has that been peer reviewed?

A Peer reviewed?

Q That procedure, doing intramuscular injections of Prostaglandin?

A In my experience, peer review takes place at the facility that you're working at, and in formal peer review,

both at Parkland Hospital and at the hospitals that I now have privileges at, it is used. I'm not certain I understand your question.

Q I'm talking about, are there peer reviewed studies of intramuscular Prostaglandin?

A I believe the only – I think I understand what you're asking. The only one, to my knowledge, that I think is the intravaginal route. However, there are other – Just because something has not been approved in use for a particular procedure does not negate its use in that particular procedure, and this is a well documented, well described use of Prostaglandin to induce labor.

[p. 303] Q Is it reported in Williams Obstetrics?

A I'm not certain whether it is or not.

Q If it wouldn't be, that would make it nonacceptable medical procedure?

A It's an accepted medical procedure because at one of the best training institutions of the country, it's done all the time. In my definition of an accepted medical procedure, the D & X is not accepted medical procedure.

Q If you knew that, let's say you knew, and I'm not saying this is the case, but suppose you found out that intact dilation and evacuation was being used at San Francisco General Hospital, would that change your opinion?

A Unless intact D & X was being used around the country all the time, I don't think it would change my opinion on it.

Q How many hospitals would have to be using it in order to change your opinion?

A I can – I don't know an answer to that. I don't think it's ever going to be done in hospitals.

Q Why is that?

A Because the people, it is a distasteful procedure that is never medically indicated to save the life of the mother and certainly not to save the life of the fetus, and that's what occurs in hospitals for the most part.

Q Have you ever had a woman – I'm sorry. You indicated that maybe 10 to 20 times you induced, essentially induced [p. 304] delivery of a dead fetus after 16 weeks, is that right?

A That's an estimate, yes.

Q And that would be 10 to 20 times since – Well, would it be since graduating from medical school?

A Since 1988.

Q So maybe one to two per year?

A About that.

Q Have any of those women ever said, I would rather not undergo an induction. I would rather do some other method?

A No.

Q If you could look at the Exhibit 7 that I handed you before and turn to page 7 of that document, I think you testified that, in essence, that induction after about 16 to 18 weeks is the method that should be used for doing abortions?

A I did not say it was a method that should be used. I said that where I practiced, that is what most people do, and that's what I do.

Q You would agree that the chart on page 7 of this document appears to indicate that no more than about 9.1% of abortions after 16 weeks are done by induction, wouldn't you?

A That's abortions.

Q Well, yeah. That's my question, about abortions.

A These are induced abortions, not indicated deliveries of demised fetuses.

[p. 305] Q I understand that. I'm asking the question about this chart.

A That's what the chart says, correct. I mean, I'm sure that's what the numbers are.

Q Is there a reason that you would be doing inductions more often with a dead fetus than to do an abortion of a live fetus?

A Since I don't practice abortion, I don't know if I can answer that question, but since, either way, you're going to end up with a dead fetus, I don't think it really matters much in my brain.

* * *

[p. 306] Q In an induction procedure where you are using Prostaglandin, now I'm talking not about abortion but delivery of a dead fetus.

A Um-hm.

Q What are the side effects of the Prostaglandin injection?

[p. 307] A You can have nausea, vomiting, diarrhea, fever.

Q In your experience, has that happened from time-to-time?

A Yes.

Q And during the induction procedure, are women able to carry on their ordinary daily activities?

A Ordinary daily activities?

Q Well, going from place-to-place, moving around, doing housework, going to their job if they have one. Are they able to do all those things during the induction procedure?

A No. They are in the hospital getting injections with Prostin every three hours.

Q And you indicated that in your experience, the patient is in labor about eight to 12 hours at the most, is that right?

A That's a guesstimate. That has been my experience. It's short, relatively short.

Q Could it be 36 hours in some cases?

A I'm sure it would be 36 hours in some cases. That hasn't been my experience.

Q I'm talking about what you have read in literature or ACOG discussions.

A It probably could go that far. I don't remember what the outlier is for that.

• • •

[p. 312] Q In terms of the procedures you do involving or have done involving dead fetuses, removal of a dead fetus?

A Um-hm.

Q Is there more bleeding that occurs in that procedure than would occur in the instance of a live fetus?

A Possibly.

Q I mean, do you think there is?

A In all likelihood, that's accurate.

Q And there is also more – I'm going to use this word more degeneration of the fetus in the sense it may have been dead for a few weeks?

A A few weeks, yes.

Q That may explain why it comes apart more easily?

A Correct.

Q Do you agree that if you dismember a fetus and remove it, there is more likelihood, let's say at 16 or 17 weeks, that there will be some bones, sharp bones that may perforate the woman's uterus?

A I cannot imagine the cartilaginous bone, the very thin bone of a 16-week baby perforating a uterus. I'm sure that somewhere it has occurred at some point or it

wouldn't even be brought up, but the chances of that occurring is – has to be extremely small.

[p. 313] Q You talked about the risk of infection from the injection from any amniocentesis-type injection. What was the risk of infection quoted by you?

A I was quoted recently by my colleagues, high risk physician, that the number was one in a thousand of infection-related events at the time of a genetic amniocentesis.

Q Assuming that that is the same for injection of Digoxin, that would be a risk on top of the preexisting risks of doing abortion, isn't that right? It's an added risk?

A If I – if I have a risk of one in a thousand of it occurring, that's really a small risk. I guess if you want –

Q It's a risk you would disclose to a patient?

A Yeah.

Q There are some risks that are probably so small you don't even disclose them because it's so completely remote, you don't – you don't disclose it at all, isn't that right?

A I disclose everything that I think is physically possible during any case, any operative procedure that I do. I mean, there are things that are unforeseen. A tile could fall out of the ceiling and hit the lady on the head. I don't disclose that to her.

Q Of course not, but I suppose the purpose of disclosing it is so she, the patient, can weigh the risks and

decide [p. 314] whether she wants to obtain that procedure?

A That's why we do informed consent.

* * *

BY MR. HELLER:

Q I think you may have said this in answer to one of my questions. I want to be clear. If a woman is pregnant and she is taking Digoxin, does that pass to the fetus?

A I'm sure that in that, we treat, we cardiovert babies that have a tachycardia with Digoxin, and it gets to the baby that way. I'm sure that some quantity of the drug does get to the baby.

Q So would it stand to reason the same would be true if you injected the fetus with Digoxin within the heart or another part of the fetus, some part of that might pass to the woman?

A I think the risk of that [sic] very, very small. Considering the reason you're doing it is to stop the heart, if you stop the heart, then the flow back and forth between the mother and baby should stop to the greatest extent, and therefore, [p. 315] the risk is extremely small.

Q Again, when you say extremely small, you're not putting a number on that. You're just saying maybe one in a thousand, would that be fair?

A I have no idea what it is, but it's got to be real small.

Q Have you reviewed the Nebraska law that's involved in this case?

A I read it, yes.

Q Do you have an opinion about what types of procedures it prohibits?

A I would – Can I get a copy of that?

Q Yeah. Let me see if I –

A I remember what it says substantially, but I can't quote it.

Q I'm going to open it to page 4 which may be the best place to start with because it contains the definition.

A Okay. Let's see here. Okay.

Q First, let me ask you, do you see the term substantial portion in that definition?

A Yes.

Q How would you define substantial portion?

A To me, that would mean that some percentage, probably over 50% of the size probably would be what that would mean. It's a vague term, but it's, you know, I would imagine that a [p. 316] substantial portion, if you are eating a substantial portion of a pie, I would say you ate half or more of the pie. That's probably what it means to me.

Q Some people might think it means 30% of the pie?

A Right. I have a large appetite.

Q Now, again, looking at that status.

A Um-hm.

Q Do you think that could cover a procedure where an abortion procedure – I'm obviously talking about here with a live fetus and the doctor has dilated the cervix and reaches into the cervix, grabs onto a leg and removes the leg while the fetus is still alive and then finishes the abortion.

A I don't think that's what, in my interpretation of this, which is what you're asking, I don't think that's what it means, no.

Q Tell me what you do think it means.

A I think that it means that in the procedure that I think is at issue here, a substantial part of the baby, meaning that a good part, 50%, 75% has been delivered, and then the life of the baby is specifically ended at that point before the head comes out so that it cannot – Its heart is not beating when the head is delivered; therefore, it's dead is what it means to me.

Q The word head, for example, doesn't even appear in the statute, isn't that right? There is no mention of a head in [p. 317] there or any other part, is there?

A It just says a substantial partial delivery – let's see – for purposes of the this provision, partial delivery of a child means killing them or child means delivery into the vagina a living or unborn child or a substantial portion thereafter. To me, it says either the whole child, nearly the whole child or a substantial portion thereof is what it says.

Q So either the whole fetus, child, or a substantial portion of it is delivered through the vagina, and then the

fetus is killed and the procedure is completed. Is that your understanding of it?

A Um-hm. My understanding is that it says substantial portion, and I guess, as you mentioned, it might mean different things to different people, but it says a substantial portion. And I know what I interpret that as. It seems pretty obvious to me what they are saying.

Q Let me ask it this way: If you were observing a physician doing an abortion?

A Okay.

Q And I understand that is distasteful to you.

A That's all right.

Q And you observed on an ultrasound camera a live fetal heartbeat, so you knew the fetus was alive at the beginning of the procedure.

[p. 318] A Okay.

Q Then you observed the physician reach in with forceps, grab onto the leg of the fetus, pull on the leg, and the leg was disjoined and removed?

A Um-hm.

Q Through the vagina.

A Um-hm.

Q Has the doctor removed a substantial portion of the living, unborn child? Do you consider the leg a substantial portion?

A I probably would not, given my interpretation of this, no.

Q What if the doctor reaches in and grabs onto something and half the fetus comes out, and then the doctor completes the procedure. Would that be substantial portion?

A I would say half or more of the baby, or three-quarters, half to three-quarters is what I would say. I read this in context of what I understand is at issue here, and to me, substantial portion means half to three-quarters of a baby, which to me would mean up to or about the chest or the head.

Q And where do you – where Have you obtained your understanding of what this law is about?

A I'm reading this, and in context of what I know is at issue here, that's the way I interpret it, and I've read – I mean, I've read numerous places about this particular [p. 319] procedure. I mean lay press, *Wall Street Journal*, I've read all kinds of places. I can't tell you exactly where I read it, but in the lay press and then obviously it has been in the OB-GYN press here for the last few months.

* * *

[p. 322] Q At about 14 weeks, is the fetus, if it's alive, is it mobile within the amniotic sac?

A Is it moving?

Q Yeah.

A It's moving. It can move. It can stay still too. They are still sometimes, and they move sometimes.

Q Would the mobility of it affect your ability, one's ability to inject a substance into the heart of the fetus?

A I guess it could if the fetus was real active.

Q And the amniotic sac as a whole, is that mobile?

A Mobile?

Q Does it move around?

A The amniotic sac?

Q Yeah. I'm trying to compare when you give an amniocentesis, when you do amniocentesis for genetic testing, you're taking fluid out of the amniotic sac. I'm trying to [p. 323] get a sense, does that move around?

A Well, I think – No, but what you are looking for is unoccupied pockets within the fetal sac, the amniotic sac, and if you are dealing with a baby that's moving, obviously, the unoccupied pockets are going to change.

* * *

Closing arguments

[p. 361] THE COURT: Let's reduce this to something less than an abstraction, maybe to something more. If a woman came in here and said, look, I want the D & X because I believe the D & X poses less risk to me. Assume that first.

MR. GRASZ: Um-hm.

THE COURT: Then assume that the evidence was undisputed that the D & X as opposed to an intact D & E or a D & X was 1% safer than a dismemberment D & E and 1% safer than an infusion, I think is the word, or a hysterotomy or hysterectomy. Are you telling me the

State of Nebraska can require that woman to undergo a greater risk of personal demise?

MR. GRASZ: I believe that the test as set forth by the U. S. Supreme Court in *Casey* as to whether it's an undue burden, they have never said that, you know, there's only one in a thousand chance procedure of risk cannot or must be used if there is another one where it's only one in 900.

THE COURT: But I'm talking about the one woman who comes in here to court and says, Judge, I can prove to you that the procedure that Dr. Carhart does is 1% safer than any other procedure, and assume that she proves that.

MR. GRASZ: Under her specific circumstances.

THE COURT: Under her specific circumstances, and assume that she does that. Are you telling me the State of Nebraska can require her, as a matter of law, to undergo that [p. 362] 1% additional risk because it – Well, are you telling me that it can do that?

MR. GRASZ: Well, first of all, I think we are talking about a constitutional challenge as applied.

THE COURT: I understand.

MR. GRASZ: And under those circumstances.

THE COURT: All right.

MR. GRASZ: In general, I think the answer has to be, yes, the Supreme Court has never said that the State's interests must be completely set aside and disregarded because of some marginal or slight increase in

risk to the woman, especially when we are talking her about children who are near viability. The State's interest, even under *Roe v. Wade*, the Court said that the State's interest increases until it is compelling, so it's a very, very strong compelling or near compelling interest that the State has, whereas, in the example you have given, the woman's interest is only very marginal and slight by comparison.

THE COURT: What if it's 5%, safer?

MR. GRASZ: Well, at some point, a court would have to determine that's an undue burden, too much risk.

THE COURT: And you think this applies previability? I mean, do you think this analysis you're suggesting to me applies previability before time that the child could survive or an extended period of time if [p. 363] delivered?

MR. GRASZ: Well, I think the question assumes that the State has not presented evidence showing that partial-birth abortion method is not safer than alternatives that are available. We're relying on our testimony, not a hypothetical to defend the statute.

THE COURT: Well, I understand, and judges ask hypotheticals to try to isolate in their own mind the arguments that counsel are making. I gave you that hypothetical so that you could respond to me hypothetically because it helps me understand your argument.

MR. GRASZ: I would certainly – It would certainly be our position that the undue burden test of *Casey* does not allow for a scenario where any marginal increase

in risk to the mother automatically outweighs, per se, the State's interest.

THE COURT: Previability.

MR. GRASZ: Yes.

THE COURT: Tell me why you get this. I mean, where do you find this law?

MR. GRASZ: Even previability, the State has very strong interests approaching compelling, especially where we are talking about late term abortions.

THE COURT: I understand the State's interest is important, but where do you get the idea that the State's [p. 364] interest previability is sufficiently important to require a woman to face a 1% greater likelihood of death. Where do you derive that analysis from any of the cases?

MR. GRASZ: Well, the Supreme Court in *Casey* said very clearly not all burdens are undue burdens.

THE COURT: Death is undue, isn't it?

MR. GRASZ: Certainly.

THE COURT: And isn't a 1% greater chance of death an undue burden to that woman?

MR. GRASZ: It could be in certain circumstances.

THE COURT: Well, she's dead. It's undue.

MR. GRASZ: There is no testimony presented here, Your Honor, that would establish even a 1% greater risk of death.

THE COURT: The AMA studies that you stipulated into evidence show. Am I wrong?

MR. GRASZ: That's out of 100,000, not out of 1,000, so we are talking a very, very, very small number.

THE COURT: Well, for the person who dies, that's a big number, right?

MR. GRASZ: It's 1.4 out of 100,000.

THE COURT: But for the person who dies, that is a large number, and that's why I'm pushing you on that, on this. I mean, that's –

MR. GRASZ: For the child that dies, it's a 100% [p. 365] number, and the State has a very strong interest in protecting unborn life, and the United States Supreme Court has recognized that.

THE COURT: But it's never been said to be the same previability, has it?

MR. GRASZ: We are talking about partially-born children for one thing. The Supreme Court has never said there is any right to kill partially-born children in any circumstance.

THE COURT: Okay. Okay. I understand that. I understand that argument, but you don't think any of the Supreme Court's jurisprudence applies here because you think this is entirely sui generis, is that right?

MR. GRASZ: Yes, Your Honor.

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